

<b>Case Number:</b>	CM14-0067462		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	05/14/2003
<b>Decision Date:</b>	12/31/2014	<b>UR Denial Date:</b>	04/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/12/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Psychiatry, Neurology and Addiction Medicine, has a subspecialty in Geriatric Psychiatry and is licensed to practice in California and Texas. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Records reviewed include 179 pages of medical and administrative records. The injured worker is a 32 year old male whose date of injury is 06/14/2003, the nature of which is unknown. The primary diagnosis is major depressive disorder single episode severe. On 10/29/13 an orthopedic re-evaluation report summarized the patient's course. He reached permanent and stationary status on 05/05/04. After that he underwent lumbar disc surgery in 2006 with physical therapy for two years, followed by what appears to have been pain management for three years. When that was stopped in 2009 he became severely depressed and had a suicide attempt in 2011 with a 2-3 week psychiatric hospitalization. On discharge he was given pain medications, then over the counter pain medications. Since that time he has been seeing [REDACTED] weekly, along with Cymbalta and gabapentin through her office. His symptoms gradually increased and normal activities of daily living became severely limited due to chronic severe low back pain with radiation to the right lower extremity. Diagnoses were status post endoscopic discectomy 2006 with persistent severe low back pain, lumbar radiculitis/radiculopathy, and chronic pain syndrome. A PR2 by [REDACTED] of 11/22/13 has the patient complaining of changes in appetite, lack of interest, and movement changes, increased eating, hiding behind overgrown beard and hat when out in public, and difficulty ambulating. Objectively he presented in pain and low energy. Discussion included a diet plan, better food consumption, and CBT homework assignments with relaxation exercises to decrease depressive symptomatology. Recommendations were for CBT, group, psychopharmacology, Cymbalta, Neurontin, melatonin, and 24/7 home care with transportation. On 01/04/14 an orthopedic evaluation status post MRI of 12/19/13 with multiple positive findings. The patient presented with severe low back pain radiating to the right lower extremity with numbness and tingling, pain being 7-8/10 with

normal activities and 9-10 with increased activities. He ambulated with a cane and had difficulty with normal activities, rest, omeprazole, and Naprosyn partially relieved symptoms. Recommendations were electrodiagnostic studies to evaluate the lumbar radiculopathy, continue home exercise, and a TENS unit for pain. He remained permanently partially disabled. In a PR2 of 02/03/14 by [REDACTED] the patient remained subjectively and objectively essentially the same. Recommendations were unchanged. An orthopedic PR2 of 04/15/14 indicated that the patient's status was essentially the same, he was having difficulty walking and standing, A PR2 of 04/02/14 by [REDACTED] indicated that pain affected the patient daily, he felt dejected due to non-resolution of pain. Treatment helps him focus less on negative and self-destructive thoughts. Objectively he appeared distressed, complaining of pain, he ambulated with a cane, and the recommendations remained the same as in the prior reports.

### **IMR ISSUES, DECISIONS AND RATIONALES**

The Final Determination was based on decisions for the disputed items/services set forth below:

**Individual cognitive behavioral therapy sessions 1 x week for 12 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological treatment Page(s): 102.

**Decision rationale:** There is no documentation found regarding the number of psychotherapy sessions the patient has received to date. The patient's subjective reports remained overall the same over time. Coping mechanisms that he had learned or was working on were not clear. His cognitive function was not addressed in reports. Objective functional improvement is not apparent with treatment received to date. There are no records beyond 04/02/14 so the patient's most current status is unknown. It is unknown if the Cymbalta is being used for depression or neuropathy. Therefore this request is not medically necessary and appropriate. Based on the California MTUS 2009 Chronic Pain Medical Treatment Guidelines, Behavioral Interventions are recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and post-traumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments incorporated into pain treatment has been found to have a positive short-term effect on pain interference and long-term effect on return to work. The following "stepped-care" approach to pain management that involves psychological intervention has been suggested: Step 1: Identify and address specific concerns about pain and enhance interventions that emphasize self-management. The role of the psychologist at this point includes education and training of pain care providers in how to screen for patients that may need early psychological intervention. Step 2: Identify patients who continue to experience pain and disability after the usual time of recovery. At this point a consultation with a psychologist allows for screening, assessment of goals, and further treatment options, including brief individual or group therapy. Step 3: Pain is sustained in spite of continued therapy (including the above

psychological care). Intensive care may be required from mental health professions allowing for a multidisciplinary treatment approach. See also Multi-disciplinary pain programs. ODG Psychotherapy Guidelines:- Up to 13-20 visits over 7-20 weeks (individual sessions), if progress is being made. (The provider should evaluate symptom improvement during the process, so treatment failures can be identified early and alternative treatment strategies can be pursued if appropriate.)- In cases of severe Major Depression or PTSD, up to 50 sessions if progress is being made.

**Group therapy sessions 1 x week for 12 weeks: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress, Group therapy

**Decision rationale:** There is no documentation found regarding the number of group sessions the patient has received to date, in fact group is not referenced within the context of the patient's psychotherapy sessions. The patient's subjective reports remained overall the same over time. In addition, Official Disability Guidelines (ODG) recommends group therapy as a supportive therapy for Post-traumatic stress disorder (PTSD) patients; this patient does not have the diagnosis of PTSD. There are no records beyond 04/02/14 so the patient's most current status is unknown. Therefore this request is not medically necessary and appropriate. California MTUS 2009 is silent regarding group therapy. ODG was utilized in the formulation of this decision. Group therapy is recommended as an option. Group therapy should provide a supportive environment in which a patient with Post-traumatic stress disorder (PTSD) may participate in therapy with other PTSD patients. While group treatment should be considered for patients with PTSD (Donovan, 2001) (Foy, 2000) (Rogers, 1999), current findings do not favor any particular type of group therapy over other types. (Foy, 2000) See also PTSD psychotherapy interventions. Number of visits should be contained within the total number of Psychotherapy visits.

**Seroquel 100mg , 2 tablets at bedtime, # 60: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress, Atypical antipsychotics

**Decision rationale:** There is no rationale provided in documentation regarding the use of Seroquel in this patient. Seroquel is an atypical antipsychotic, which are FDA approved for schizophrenia and bipolar disorder, neither of which is a diagnosis which this patient carries. It is often used off-label in the community for insomnia, however it is not a first line agent. There is reference in a PR2 that the patient has sleep difficulty, but no record of other symptoms or

medications attempted. This request is not medically necessary and appropriate. CA MTUS 2009 is silent Seroquel. Official Disability Guidelines (ODG) was utilized in the formulation of this decision. Not recommended as a first-line treatment. There is insufficient evidence to recommend atypical antipsychotics (eg, quetiapine, risperidone) for conditions covered in ODG. See Post-traumatic stress disorder (PTSD) pharmacotherapy. Adding an atypical antipsychotic to an antidepressant provides limited improvement in depressive symptoms in adults, new research suggests. The meta-analysis also shows that the benefits of antipsychotics in terms of quality of life and improved functioning are small to nonexistent, and there is abundant evidence of potential treatment-related harm. The authors said that it is not certain that these drugs have a favorable benefit-to-risk profile. Clinicians should be very careful in using these medications. (Spielmans, 2013) The American Psychiatric Association (APA) has released a list of specific uses of common antipsychotic medications that are potentially unnecessary and sometimes harmful. Antipsychotic drugs should not be first-line treatment to treat behavioral problems. Antipsychotics should be far down on the list of medications that should be used for insomnia, yet there are many prescribers using quetiapine (Seroquel), for instance, as a first line for sleep, and there is no good evidence to support this. Antipsychotic drugs should not be first-line treatment for dementia, because there is no evidence that antipsychotics treat dementia. (APA, 2013) Antipsychotic drugs are commonly prescribed off-label for a number of disorders outside of their FDA-approved indications, schizophrenia and bipolar disorder. In a new study funded by the National Institute of Mental Health, four of the antipsychotics most commonly prescribed off label for use in patients over 40 were found to lack both safety and effectiveness. The four atypical antipsychotics were aripiprazole (Abilify), olanzapine (Zyprexa), quetiapine (Seroquel), and risperidone (Risperdal). The authors concluded that off-label use of these drugs in people over 40 should be short-term, and undertaken with caution. (Jin, 2013) Atypical antipsychotic medications are linked to acute kidney injury (AKI) in elderly patients. A population-based study examining medical records for nearly 200,000 adults showed that those who received a prescription for quetiapine (Seroquel), risperidone (Risperdal), or olanzapine had an almost 2-fold increased risk for hospitalization for AKI within the next 90 days vs those who did not receive these prescriptions. In addition, patients who received one of these oral atypical antipsychotics had increased risk for acute urinary retention, hypotension, and even death. (Hwang, 2014).

**Neurontin 400mg, 1 tablet twice daily, 2 tablets at bedtime, # 120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Gabapentin Page(s): 49.

**Decision rationale:** There is no documentation in records provided that this patient is being prescribed Neurontin (gabapentin) currently. The only reference to Neurontin is in [REDACTED] notes as a treatment plan. It is not found in current orthopedic records as part of his medication regimen for relief of radicular symptoms. Therefore this request is not medically necessary and appropriate. The California Medical Treatment Utilization Schedule (MTUS) 2009 Chronic Pain Medical Treatment Guidelines. Gabapentin is an anti-epilepsy drug (AEDs - also referred to as

anti-convulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. See Antiepilepsy drugs (AEDs) for general guidelines, as well as specific Gabapentin listing for more information and references.

**Twenty four seven home care by a psych technician or skilled LVN: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Home Health Services

**Decision rationale:** Documentation does not support the necessity for this service by a psych technician or a skilled LVN. He is not receiving services requiring a licensed medical professional such as IV medications, dressing changes, physical therapy, etc. Records reflect that he has diminished activities, but not that he is unable to perform activities. There is no evidence that the patient is home bound. There was no evaluation of medical necessity or treatment plan provided. Needs such as housekeeping and shopping do not require licensed personnel, and can be performed by a competent housekeeper with a valid driver's license. This request is not medically necessary and appropriate. California MTUS 2009 is silent regarding home care or home health services. ODG was utilized in the formulation of this decision. These services include both medical and non-medical services for patients who are home bound and who require one or a combination of the following: (1) Skilled nursing care by a licensed medical professional for tasks such as administration of intravenous drugs, dressing changes, physical therapy, speech-language pathology services, and occupational therapy; (2) Home health aide services for health-related tasks and assistance with activities of daily living that do not require skills of a medical professional, such as bowel and bladder care, feeding, bathing, dressing and transfer and assistance with administration of oral medications; and/or (3) Domestic services such as shopping, cleaning, laundry that the individual is no longer capable of performing due to the illness or injury. These services do not require specialized training and do not need to be performed by a medical professional. Home health care services are medically necessary where the medical condition results in an inability to leave the home for medical treatment and/or an inability to perform specific custodial or homemaker services. (Ellenbecker, 2008) (ACMQ, 2000) (CMS, 2004) Justification for medical necessity of Home health services requires documentation of:(1) The medical condition that necessitates home health services, including objective deficits in function and the specific activities precluded by such deficits;(2) The expected kinds of services that will be required, with an estimate of the duration and frequency of such services; &(3) The level of expertise and/or professional licensure required to provide the services.Evaluation of the medical necessity of Home Health Care services must be made on a case-by-case basis. The physician's treatment plan usually includes an in-home evaluation by a Home Health Care Agency Registered Nurse to assess the appropriate scope, extent and level of care for home health care services. A one-time home health care evaluation is appropriate if the treatment plan is unclear and not already ordered by the treating physician.