

<b>Case Number:</b>	CM14-0072857		
<b>Date Assigned:</b>	06/30/2014	<b>Date of Injury:</b>	10/14/2002
<b>Decision Date:</b>	08/15/2014	<b>UR Denial Date:</b>	03/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/07/2014

### 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, 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 272 pages of medical and administrative records. The injured worker is a 38 year old male whose date of injury is 10/14/02, which occurred while manipulating a ladder in the bed of a truck. His diagnosis is brachial plexus lesions. Records indicate that the patient suffers from upper extremity pain bilaterally which radiates to his hands. His medications included Adderall 20mg twice per day, Klonopin 1mg at bedtime, Lamictal 150mg at bedtime, Trazodone 50-150mg at bedtime, and Nucynta (which afforded him partial pain relief). He continued to have sleep disturbance due to pain, which resulted in daytime drowsiness. Treatments have included injections to the wrist, scapula and brachial plexus, 3 shoulder surgeries, pain management, psychotropic medication and psychotherapy. In 2013 he was diagnosed with CRPS. Psychiatrically he was diagnosed with major depression severe with psychotic features, anxiety disorder not otherwise specified, and pain disorder associated with both psychological factors and a general medical condition. At one point in 2011 he apparently showed psychotic features including visual hallucinations, records are unclear as to the course and treatment of those symptoms. In supplemental medical-legal evaluations in psychiatry of 09/04/12 and 08/20/12 it was noted that the patient had been prescribed Adderall as a booster to his antidepressants. The patient did not however appear to be on antidepressants. It was helpful in lifting his brain fog, and he had been stable and functioning well at college in terms of his depression and cognitive functioning. Agreed supplemental medical-legal evaluation in psychiatry of 01/14/13 by [REDACTED] (psychiatrist) updates the patient's diagnoses to show the major depression as being in partial remission. The patient was focused, attentive, and concentration was good. There was mention that the patient was planning to study accounting. Affect was well contained with occasional sadness, mood was euthymic. In an

industrial injury report by [REDACTED] (psychiatrist) of 04/10/14 the patient reported that he continued in his college studies. After pain injections he gets 90% relief for 3-5 months. He felt that the Klonopin was effective for anxiety and racing thoughts and the Lamictal stabilizes his mood, as well as helping with chronic pain. He was taking Trazodone 100mg for sleep. He was seeing his psychologist at that point on an as needed basis, at that point he had not seen in 6-8 months. There is a PR2 of 04/17/14 by [REDACTED] (pain management), who prescribes the Adderall. [REDACTED] handwritten note appears to state improved mood under subjective, under treatment plan, again handwritten, he refers to Adderall see page 5 however that did not appear to be provided. It is unclear why Adderall is being prescribed by the pain management specialist and not the psychiatrist.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **1 Prescription for Adderall 20mg #60: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Other Medical Treatment Guideline or Medical Evidence: Adderall IR Prescribing Information. United States Food and Drug Administration arch 2007. P.t. November 2013, Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association. (5th Ed) 2013.

**Decision rationale:** CA-MTUS, ACOEM, and ODG do not reference Adderall, either as an adjunct in the treatment of any of the depressive disorders, or as a treatment of attention deficit disorder/hyperactivity disorder. As such, other medical treatment guidelines and evidence was utilized in the formulation of this decision. The patient was being prescribed Adderall ostensibly as a booster to his antidepressants. The patient attested to the fact that it was helpful in lifting his brain fog, and he was described in reports as doing well and functioning well cognitively in college. Adderall is indicated for attention deficit hyperactivity disorder and excessive daytime sleepiness due to narcolepsy (see FDA indications). The patient has attested to the fact that his daytime sleepiness is due to pain interrupting his sleep. He has not been diagnosed with attention deficit disorder. There is no description of clear-cut symptomatology on record, nor are there any diagnostic rating scales provided such as the Conners Adult ADHD or Brown Adult ADD scales. There is no evidence that the patient met criteria per DSM-V for the diagnosis of attention deficit disorder/attention deficit hyperactivity disorder. There is no documentation of the benefit that this patient is receiving directly from the Adderall, except for improved mood, statements that he is stable and doing well in college cognitively, and that the patient endorsed the fact that his brain fog had lifted. While it is common in the community to use psychostimulants such as Adderall as a beneficial adjunct to antidepressant treatment, this patient is not on an antidepressant. Therefore, the request for 1 prescription for Adderall 20mg #60 is not medically necessary and appropriate.