

Case Number:	CM14-0188425		
Date Assigned:	11/19/2014	Date of Injury:	01/23/2002
Decision Date:	01/07/2015	UR Denial Date:	10/29/2014
Priority:	Standard	Application Received:	11/12/2014

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 Family Medicine and is licensed to practice in Ohio. 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:

The injured worker is a 64 year old female with a date of injury of 7-24-2002. The diagnoses include cervical radiculopathy, lumbar radiculopathy, lumbar spine sprain, carpal tunnel syndrome, major depressive disorder, anxiety, psychosis, and psychological factors affecting a medical condition. She has been prescribed Klonopin 0.5 mg at bedtime for anxiety, Ambien 10 mg at bedtime for insomnia, Celexa 40 mg a day for depression, and Seroquel 400 mg, 2 at bedtime for psychosis. She participates in monthly to weekly cognitive behavioral sessions. She continues to report depressive symptoms. She sleeps 5-6 hours per night. She has hallucinations when denied access to her medications. The treating provider notes that slight progress has been made with activities of daily living as a result of therapy. Detailed psychological/psychiatric reports are not included for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Klonopin 0.5mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: Benzodiazepines like Klonopin are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. In this instance, the rationale for continued, long-term use of Klonopin is not provided. Because of the known tolerance to the anti-anxiety effects of benzodiazepines that occur with chronic use and the possibility that anxiety may worsen as a result, Klonopin 0.5mg #30 was not medically necessary.

Seroquel 400mg #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 (ODG), Mental Illness and Stress, Anti-Psychotics.

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 and Stress, Atypical Anti-Psychotics.

Decision rationale: Atypical anti-psychotic medications such as Seroquel are not recommended as a first-line treatment. There is insufficient evidence to recommend atypical anti-psychotics (e.g., Quetiapine, Risperidone) for conditions covered in ODG. Adding an atypical anti-psychotic 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. The American Psychiatric Association (APA) has released a list of specific uses of common antipsychotic medications that are potentially unnecessary and sometimes harmful. Anti-psychotic 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. 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. 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. In this instance, the psychological/psychiatric notes provided are hand-written and sparse. There is no discussion as to why the Seroquel is being used off-label without a diagnosis of bipolar disorder or schizophrenia. The above cited reference from the National Institute of Mental Health suggests that Seroquel should be used short-term for those over the age of 40 when being used off-label. The rationale for long-term use of this medication is not provided. Therefore, Seroquel 400mg #60 is not medically necessary per the referenced guidelines.

Celexa 40mg #30: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Mental Illness and Stress, Anti-Depressants.

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 and Stress, Anti-Depressants.

Decision rationale: Anti-depressants are recommended for initial treatment of presentations of Major Depressive Disorder (MDD) that are moderate, severe, or psychotic, unless electroconvulsive therapy is part of the treatment plan. Not recommended for mild symptoms. Professional standards defer somewhat to patient preference, allowing for a treatment plan for mild to moderate MDD to potentially exclude antidepressant medication in favor of psychotherapy if the patient favors such an approach. (American Psychiatric Association, 2006) A randomized controlled trial has indicated that the patient's smoking status is a credible factor that can be considered in the treatment plan. Specifically, antidepressant medication (fluoxetine/Prozac) has been found to compromise the success of smoking cessation efforts. Consequently, if the patient is attempting to quit smoking, that effort causes antidepressant medication to be a less attractive treatment option than standards typically indicate (this consideration will be most relevant to presentations of MDD which are mild to moderate in current severity). Drug selection criteria, The American Psychiatric Association has published the following considerations regarding the various types of anti-depressant medications: (1) Many treatment plans start with a category of medication called selective serotonin reuptake inhibitors (SSRIs), because of demonstrated effectiveness and less severe side effects; Celexa is an SSRI. (2) In addition to the SSRIs, other anti-depressant medications that are likely to be optimal for most patients include Desipramine, Nortriptyline, Bupropion, and Venlafaxine; (3) Another group of antidepressant medications, called monoamine oxidase inhibitors (MAOIs), are not recommended as a primary treatment option, because they are associated with serious side effects, and they necessitate dietary restrictions. This category of medication should be considered only for cases that do not respond to other options. Antidepressants offer significant benefit in the treatment of the severest depressive symptoms, but may have little or no therapeutic benefit over and above placebo in patients with mild to moderate depression. A recent meta-analysis concluded that drug effects were nonexistent to negligible among depressed

patients with mild, moderate, and even severe baseline symptoms, whereas they were large for patients with very severe symptoms, but the majority of depressed patients presenting for treatment do not fall into that very severe category. Major clinical trials tend to exclude patients in the mild to moderate range. This study raises the question of whether patients with mild to moderate depression should have antidepressant therapy as a first-line approach. In this instance, the treating provider notes slight progress with regard to activities of daily living as a consequence of the medication. While the UR physicians have previously denied Celexa because of a lack of progress documented by questionnaires, the referenced guidelines do not stipulate such documentation as a criterion for continuing antidepressants. The UR physicians also disallowed Celexa on the basis that it was not on the ODG formulary as a 'Y' drug. In this instance, the injured worker has been taking Celexa for several years and the original appeal/approval documentation would not likely be re-submitted as the requirement is to submit 6 months of medical documentation for review purposes. Therefore, Celexa 40mg #30 was medically necessary.

Ambien 10mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWA, Insomnia.

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

Decision rationale: Zolpidem (Ambien) is approved for the short-term (usually two to six weeks) treatment of insomnia. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. Zolpidem (Ambien) increases the ability to remember images, but only those that have negative or highly arousing content. The findings have potential ramifications for patients prescribed Zolpidem for relief of insomnia due to anxiety disorders, including post-traumatic stress disorder (PTSD). Physicians should watch out for this counter-therapeutic effect in patients with anxiety disorders and PTSD, because these are people who already have heightened memory for negative and high-arousal memories. In this instance, The Ambien appears to have been in continuous use for several months if not years. The cited guidelines do not recommend use beyond 2-6 weeks. Therefore, Ambien 10mg #30 was not medically necessary.