

Case Number:	CM15-0168351		
Date Assigned:	09/09/2015	Date of Injury:	03/19/2002
Decision Date:	10/14/2015	UR Denial Date:	08/12/2015
Priority:	Standard	Application Received:	08/26/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

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

This injured worker is a 52 year old female who reported an industrial injury on 3-19-2002. Her diagnoses, and or impression, were noted to include: thoracic and lumbar strain-sprain; lumbar radiculitis; major depressive disorder; psychological symptoms; and other alopecia. No current imaging studies were noted. Her treatments were noted to include: an agreed medical re-evaluation on 1-27-2014; acupuncture treatments; psychiatric evaluation and treatment; psychotherapy sessions; pain management and the weaning of medications; and rest from work as she was noted to be 100% disabled. The psychiatric progress notes of 7-27-2015 reported complaints which included: she was feeling awful; getting no sleep; anxiety was too high; was very depressed; a worsening of symptoms since discontinuing medications due to lack of sleep and not receiving certain medications which had been denied by workman's compensation; that she was taking Motrin for her persistent low back and neck pain; anhedonia; anger; diminished energy; impaired concentration and memory; irritability; low self-esteem; and suicidal ideations. Objective findings were noted to include: obvious physical discomfort with high levels of anxiety, depression, agitation and irritability; an agitated, tangential, reactive low mood; poor (illegible); and the notations that she must re-start her medications immediately due to regression; and the re-starting Lorazepam at half the previous dose, to be taken as needed for anxiety. The "BAI" and "BDI" forms were noted filled out by the injured worker at this visit. The physician's requests for treatments, on the 8-4-2015 Request for Authorization, were noted to include a Beck Anxiety Inventory, 4 medication management sessions, and Lorazepam. The

Utilization Review of 8-11-2015 non-certified the request for Beck Anxiety Inventory and Lorazepam, and modified certification of the medication management sessions to 1 session.

IMR ISSUES, DECISIONS AND RATIONALES

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

Beck Anxiety Inventory: Overturned

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 Official Disability Guidelines (ODG) Mental Illness Chapter, under BDI - II (Beck's Depression Inventory) and Other Medical Treatment Guidelines www.ncbi.nlm.nih.gov/pmc/articles/PMC3879951/.

Decision rationale: The patient was injured on 03/19/020 and presents with low back pain. The request is for BECK ANXIETY INVENTORY. The utilization review denial letter did not provide a rationale. The RFA is dated 08/04/15 and the patient is not currently working, as she is 100% disabled. ODG guidelines Mental Illness Chapter, under BDI - II (Beck's Depression Inventory): "Recommended as a first-line option psychological test in the assessment of chronic pain patients. See Psychological evaluations. Intended as a brief measure of depression, this test is useful as a screen or as one test in a more comprehensive evaluation. Can identify patients needing referral for further assessment and treatment for depression. Strengths: Well-known, well researched, keyed to DSM-IV criteria, brief, appropriate for ages 13-80. Weaknesses: Limited to assessment of depression, easily faked. Scale is unable to identify a non-depressed state, and is thus very prone to false positive findings. Should not be used as a stand-alone measure, especially when secondary gain is present."

www.ncbi.nlm.nih.gov/pmc/articles/PMC3879951/, states: Purpose: The BAI is a brief measure of anxiety with a focus on somatic symptoms of anxiety that was developed as a measure adept at discriminating between anxiety and depression (18). Content: The BAI is administered via self-report and includes assessment of symptoms such as nervousness, dizziness, inability to relax, etc. Number of items: The BAI has a total of 21 items. Response options/scale: Respondents indicate how much they have been bothered by each symptom over the past week. Responses are rated on a 4-point Likert scale and range from 0 (not at all) to 3 (severely). Examples of use: The BAI is used in efforts to obtain a purer measure of anxiety that is relatively independent of depression. Increasing use of this measure has been observed in a number of rheumatic conditions including fibromyalgia (19) and arthritis (20). The patient is diagnosed with thoracic and lumbar strain-sprain, lumbar radiculitis, major depressive disorder, psychological symptoms, and other alopecia. Treatment to date included acupuncture treatments, psychiatric evaluation and treatment, psychotherapy sessions, pain management and the weaning of medication, and rest from work as she was noted to be 100% disabled. The 07/27/15 report states that the patient was feeling awful, getting no sleep, anxiety was too high, and was very depressed. Given that the patient continues to suffer from anxiety and depression, the request IS medically necessary.

Medication management, 4 sessions: Overturned

Claims Administrator guideline: Decision based on MTUS Stress-Related Conditions 2004. Decision based on Non-MTUS Citation Official Disability Guidelines: Mental Illness & Stress - Office visits.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chapter 7, Independent Medical Examination and Consultation Chapter under Consultation Section, page 127.

Decision rationale: The patient was injured on 03/19/020 and presents with low back pain. The request is for MEDICATION MANAGEMENT, 4 SESSIONS. The utilization review denial letter did not provide a rationale. The RFA is dated 08/04/15 and the patient is not currently working, as she is 100% disabled. MTUS/ ACOEM Guidelines, Chapter 7, Independent Medical Examination and Consultation Chapter under Consultation Section, page 127 states, "The occupational health practitioner may refer to other specialists if the diagnosis is not certain or extremely complex, when psychosocial factors are present, and the plan or course of care may benefit from additional expertise." MTUS page 8 also requires that the treater provides monitoring of the patient's progress and makes appropriate recommendations. The patient is diagnosed with thoracic and lumbar strain-sprain, lumbar radiculitis, major depressive disorder, psychological symptoms, and other alopecia. Treatment to date included acupuncture treatments, psychiatric evaluation and treatment, psychotherapy sessions, pain management and the weaning of medication, and rest from work as she was noted to be 100% disabled. As of 07/08/15, the patient is taking Norco, Soma, and Motrin. The reason for the request is not provided and there is no discussion provided regarding why the patient needs 4 sessions of medication management. However, given the patient's lower back pain, MTUS supports regular visitations to report on the patient's progress. The request IS medically necessary.

Lorazepam 0.5 mg Qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

Decision rationale: The patient was injured on 03/19/020 and presents with low back pain. The request is for LORAZEPAM 0.5 MG QTY 60. The utilization review rationale is that this medication has "associated dangers and [there is] lack of documented improvements with prior use of this medication." The RFA is dated 08/04/15 and the patient is not currently working, as she is 100% disabled. Lorazepam is not mentioned on any of the treatment reports provided prior to the UR date. There is no indication of when the patient began taking this medication and the report with the request is not provided. MTUS, Benzodiazepines Section, page 24 states: Benzodiazepines such as Xanax 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." The patient is diagnosed with thoracic and lumbar strain-sprain, lumbar radiculitis, major depressive disorder, psychological symptoms, and other alopecia. Treatment to date included acupuncture treatments, psychiatric evaluation and treatment, psychotherapy sessions, pain management and the weaning of medication, and rest from work as she was noted to be 100% disabled. The 07/27/15 report states that the patient was feeling awful, getting no sleep, anxiety was too high, and was very depressed. It appears that this is the patient's initial trial of this medication. However, MTUS and ODG do not support long-term use of this medication. The treater does not explain how long this medication will be used and there is no plan for taper. The request IS NOT medically necessary.