

<b>Case Number:</b>	CM15-0195510		
<b>Date Assigned:</b>	10/12/2015	<b>Date of Injury:</b>	06/17/2013
<b>Decision Date:</b>	12/14/2015	<b>UR Denial Date:</b>	09/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/05/2015

### 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: Emergency Medicine

### 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 49 year old male who sustained an industrial injury on 6-17-13. A review of the medical records indicates he is undergoing treatment for major depressive disorder single episode severe, with psychotic features, insomnia related to depression, somatic symptoms disorder predominantly pain, and chronic pain. He also has diagnoses of myofascial pain syndrome lumbar, degeneration of lumbar disc, and low back pain. Medical records (8-11-15 to 8-19-15) indicates ongoing complaints of "total body pain", depressed mood with anhedonia, poor concentration and memory, poor self-esteem, feelings of uselessness, hopelessness, helplessness, anxiety, decreased energy and fatigue, and continual chronic suicidal ideation. The treating provider indicates that he denies having a plan to kill or hurt himself. The mental status exam (8-19-15) reveals that the injured worker is "adequately groomed." He is noted to be "more cooperative, less despondent, not dramatic, less negativistic, and less irritable." His eye contact is noted to be "slightly better." His mood is depressed, anxious, and dysphoric. No delusions, paranoia, or obsessive thoughts are noted. No "current" suicidal ideation or homicidal ideation is noted. No thoughts of self-injury are noted. The treating provider indicates that his attention and concentration are "improved-loses the line of the interview less frequently - requires repetition of the questions and redirection." His memory is "forgetful." The treating provider indicates that his judgment is "improved - agrees to cooperate with medication management and psychotherapy." The treatment plan is to restart Remeron 15mg at bedtime x 5 days, then increase to 30mg at bedtime daily for depression, anxiety, and insomnia, continue Neurontin 1200mg three times daily for chronic pain, continue

Seroquel 25mg at bedtime daily for psychosis, insomnia, and to augment Remeron for depression. A request for authorization includes 2 refills of the above-noted medications. The treatment is also to start group psycho-education for anxiety and depression, as well as continue individual cognitive behavioral therapy for chronic pain. He is noted to have completed two sessions of individual therapy. The utilization review (9-15-15) indicates requests for authorization of Neurontin 1200mg three times daily #180 with 2 refills, Seroquel 25mg #30 with 2 refills, monthly medication management x 6, group cognitive behavioral therapy, weekly x 6, and individual cognitive behavioral therapy, weekly x 6. Modification of Remeron and Seroquel was made to include one refill. Monthly medication management was modified to "x 4." Group and individual cognitive behavioral therapies were denied.

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

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

**Remeron 15 mg #60 with 2 refills: 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 Official Disability Guidelines (ODG) Pain (chronic)/Antidepressants for chronic pain.

**Decision rationale:** Medications in the class of antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. (Feuerstein, 1997) (Perrot, 2006) They are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect usually takes longer to occur. (Saarto-Cochrane, 2005) Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality/duration, and psychological assessment. Side effects can include excessive sedation and should be assessed. It is recommended that these outcome measurements should be initiated at one week of treatment with a recommended trial of at a minimum of 4 weeks. It has been suggested that if pain is in remission for 3-6 months, a gradual tapering of anti-depressants can be undertaken. In this case, the use of this medication is certified for use. At issue is the number of refills requested. Re-evaluation for efficacy and side-effects seen would be appropriate prior to continued use. As such, the request is not medically necessary pending re-evaluation.

**Neurontin 1200 mg #180 with 2 refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

**Decision rationale:** The request is for the use of a medication in the category of an anti-epileptic drug (AED). These medications are recommended for certain types of neuropathic pain. Most of the randomized clinical control trials involved include post-herpetic neuralgia and painful polyneuropathy such as in diabetes. There are few trials which have studied central pain or radiculopathy. The MTUS guidelines state that a good response to treatment is 50% reduction in pain. At least a 30% reduction in pain is required for ongoing use, and if this is not seen, this should trigger a change in therapy. There also should be documentation of functional improvement and side effects incurred with use. Disease states which prompt use of these medications include post-herpetic neuralgia, spinal cord injury, chronic regional pain syndrome, lumbar spinal stenosis, post-operative pain, and central pain. There is inadequate evidence to support use in non-specific axial low back pain or myofascial pain. In this case, there is lack of documentation of the reasoning for use, as there is no clear evidence of neuropathic pain seen. There is also no documentation of pain reduction or functional improvement seen. Pending clarification, the request is not medically necessary.

**Seroquel 25 mg #30 with 2 refills:** 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 Official Disability Guidelines (ODG) Mental illness & stress/Atypical antipsychotics.

**Decision rationale:** The request is for a medication in the category of an atypical antipsychotic. The official disability guidelines state the following regarding this topic: Not recommended as a first-line treatment. There is insufficient evidence to recommend atypical antipsychotics (e.g., quetiapine, risperidone) as monotherapy for conditions covered in ODG. See 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. (Spielman, 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) More than half of the prescriptions for antipsychotics are prescribed to patients with no diagnosis of a serious mental illness. They are more likely to be prescribed to older people, who may be more sensitive to adverse effects such as movement disorders and cardiometabolic risk. Providers should use caution concerning the use of antipsychotics for patients who do not have a diagnosis of psychosis, since the drugs are associated with serious adverse effects, including extrapyramidal symptoms with first-generation antipsychotics and weight gain and lipid/glucose dysregulation with second-generation agents. Moreover, antipsychotics may be linked to increased rates of stroke and all-cause mortality in patients with dementia. (Marston, 2014) In this case, the use of this medication is indicated. At issue is the number of refills requested. Prior to continued use, re-evaluation for effectiveness and side-effects seen would be appropriate. As such, the request is not medically necessary.

#### **Monthly medication management x 6: 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 Official Disability Guidelines (ODG) Mental Illness & Stress/Office visits.

**Decision rationale:** The request is for office visits. The official disability guidelines state the following regarding this topic: Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA

may serve as a "flag" to payors for possible evaluation, however, payors should not automatically deny payment for these if preauthorization has not been obtained. Note: The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of "virtual visits" compared with inpatient visits, however the value of patient/doctor interventions has not been questioned. (Dixon, 2008) (Wallace, 2004) Further, ODG does provide guidance for therapeutic office visits not included among the E&M codes, for example Chiropractic manipulation and Physical/Occupational therapy. In this case, the office visits requested are indicated for re-evaluation and monitoring. At issue is the number of visits requested. Further visits can be requested depending of the patient's progress over the next 4 months. As such, the request is not medically necessary.

### **Group CBT, weekly x 6: Upheld**

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

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

**Decision rationale:** The request is for the use of cognitive behavioral therapy. The MTUS guidelines advise screening patients who are at risk for delayed recovery including fear avoidance beliefs. Initial therapy for "at risk" patients should be physical medicine for exercise instruction using a cognitive motivational approach. If there is lack of progress after 4 weeks of treatment, psychotherapy cognitive behavioral therapy can be considered. If there is evidence of functional improvement, 6-10 visits over 5-6 weeks are indicated. In this case, there is lack of documentation of the results of a trial of physical medicine for exercise instruction which is needed. As such, the request is not medically necessary.

### **Individual CBT, weekly x 6: 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 Official Disability Guidelines (ODG) Mental Illness & Stress/Cognitive behavioral therapy.

**Decision rationale:** The request is for cognitive behavioral therapy. The official disability guidelines state the following regarding this topic: Studies show that a 4 to 6 session trial should be sufficient to provide evidence of symptom improvement, but functioning and quality of life indices do not change as markedly within a short duration of psychotherapy as do symptom-based outcome measures. (Crits-Christoph, 2001) CBT, whether self-guided, provided via telephone or computer, or provided face to face, is better than no care in a primary care setting and is also better than treatment as usual, according to a meta-analysis. A subanalysis showed the

strongest evidence for CBT in anxiety. For depression alone, CBT compared with no treatment had a medium effect size, computerized CBT had a medium effect, and guided self-help CBT for both depression and anxiety produced a small effect size. (Twomey, 2014) See Number of psychotherapy sessions for more information. 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. In this case, there is inadequate documentation of symptom improvement or gains seen for continued treatment and further therapy would not be guideline-supported. As such, the request is not medically necessary.