

Case Number:	CM15-0207978		
Date Assigned:	10/26/2015	Date of Injury:	08/12/2011
Decision Date:	12/11/2015	UR Denial Date:	10/01/2015
Priority:	Standard	Application Received:	10/22/2015

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, Texas

Certification(s)/Specialty: Psychiatry, Geriatric Psychiatry, Addiction Psychiatry

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 47 year old female who sustained an industrial injury on 08/12/2011. She hit the center divider at around 50mph with injury to the neck, teeth, left shoulder, low back, left lower leg and psyche. Her PTSD dates back to around 2002 when she was threatened by a gang member. Other diagnoses include depressive disorder NOS and panic disorder with agoraphobia. Treatment to date has included psychiatric care, therapy and medication. Her medication history is somewhat unclear. On 03/20/15, she saw [REDACTED] for initial psychiatric evaluation. She reported anxiety, tension, irritability, and quick temper most of the time, depression some of the time, occasional crying, and rare feelings that life is not worth living with rare suicidal ideation without intent/plan. Her memory and concentration were impaired, energy level was low and sociability was low. [REDACTED] reported that she was previously on Buspar (dates unspecified). He continued Ambien, Wellbutrin SR 100mg QD, and gave her Ativan 1mg TID prn. On 05/01/15, she reported that the meds were helpful but not strong enough. Ativan and Ambien were continued. On 05/29/15 Xanax 2mg TID prn anxiety and Restoril 30mg up to 2 at HS were added. Wellbutrin was increased to 200mg BID. On 06/26/15 the patient reported that Xanax was more effective than her prior Valium (it is unclear when she received Valium). She was given Prazosin for nightmares. She reported reduced insomnia, panic attacks, anxiety, tension, irritability, quick temper and depression. Other symptoms were unchanged. She stated that she had little benefit from biofeedback and group, and was seeking individual therapy. Xanax and "Risperdal" are helpful. On 08/28/2015, the report is the same. On 07/02/15, UR modified Xanax #90 to #68, and Restoril #60 to #45. On 07/22/15, UR modified

Xanax to #51, and Restoril #34. On 07/29/15, UR modified Ativan #90 to #53, and on 08/17/15, UR denied Ativan. On 08/24/15, there is an appeal from ██████ regarding the Ativan denial. On 09/29/15 there is an RFA requesting CBT and Xanax, There is a final IMR determination letter of 09/29/15 overturning the Xanax decision, certifying #90 as medically necessary and appropriate for prn use in small amounts (#90) as she suffered from ongoing pain, dysphoria, and anxiety; but non-certifying Restoril. UR of 10/01/15 modified Xanax #120 to #90, Restoril to #60 to 45, and CBT x12 was modified to six.

IMR ISSUES, DECISIONS AND RATIONALES

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

Xanax 2mg, #120 (4x a day): Upheld

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

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, PTSD pharmacotherapy.

Decision rationale: ODG recommends against the long-term use of benzodiazepines to manage core symptoms in PTSD, and strongly recommend selective serotonin reuptake inhibitors (SSRIs) for the treatment of PTSD, tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs) as second-line treatments for PTSD, or a second-generation (e.g., nefazodone, trazodone, venlafaxine, mirtazapine, bupropion) in the management of PTSD. Consider prazosin to augment the management of nightmares and other symptoms of PTSD. The patient is on Wellbutrin SR 200mg BID and Prazosin. She has reported improvement in symptoms since her initial psychiatric evaluation of 03/20/15. It is unclear when she was on Buspar and what effect it had. Xanax was added on 05/29/15 and it appears that she was on that and Ativan simultaneously, in addition to Restoril 30mg up to 2 at HS. This is quite a high benzodiazepine load, which would place one at risk for any of a number of side effects from falls to cognitive impairment. A final IMR determination on 09/29/15 allowed for Xanax #90 to be prescribed on a prn basis. UR of 10/01/15 modified the request for Xanax 0.5mg #120 to #90. This request is clearly outside of guidelines, and the IMR above. This request is not medically necessary.

Restoril 30mg, #60: Upheld

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

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

Decision rationale: Recommend that treatment be based on the etiology. Pharmacologic agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. The specific component of insomnia should be addressed: (a) Sleep onset; (b) Sleep maintenance; (c) Sleep quality; & (d) Next-day functioning. There are four main categories of pharmacologic treatment: (1) Benzodiazepines; (2) Non-benzodiazepines; (3) Melatonin receptor agonists; & (4) Sedating antihistamines (primarily over-the-counter medications). Benzodiazepines are only recommended for short-term use due to risk of tolerance, dependence, and adverse events (daytime drowsiness, anterograde amnesia, next-day sedation, impaired cognition, impaired psychomotor function, and rebound insomnia). These drugs have been associated with sleep-related activities such as sleep driving, cooking and eating food, and making phone calls (all while asleep). Particular concern is noted for patients at risk for abuse or addiction. This has been prescribed for an extended time beyond recommended guidelines without rationale for its continued use which would include a more detailed description of improvement of insomnia, e.g. report of number of hours slept, time to sleep onset, etc. There was no evidence that nonpharmacologic methods were attempted such as sleep hygiene education, progressive muscle relaxation, meditation, etc. There are other agents having more favorable side effect profiles than benzodiazepines, it does not appear that these have been attempted either (Rozerem, melatonin). UR's have repeatedly modified this request, then it was denied. This request is not medically necessary.

Cognitive behavioral therapy x12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Psychological treatment.

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, PTSD psychotherapy interventions.

Decision rationale: Recommended by ODG Psychotherapy interventions are aimed at reduction of symptoms severity and improvement of global functioning. However, the clinical relevance and importance of other outcome indicators (e.g., improvement of quality of life, physical and mental health) are not currently well known. 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. ODG allows up to 13-20 visits over 7-20 weeks (individual sessions), if progress is being made, and up to 50 sessions for severe cases of severe major depression or PTSD (if progress is being made). There was no documentation provided to show the rationale behind this request. The patient reported improvement in her symptoms. No clear cut description of psychological distress was evidenced. She is on Wellbutrin SR and Prazosin, both of which seem to be beneficial per report. Six CBT sessions were certified but no reports were provided showing that she received services. If she did have these sessions, objective functional improvement must be shown prior to additional certification. This request is not medically necessary.

