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| Case Number: | CM13-0034071 | | |
| Date Assigned: | 12/06/2013 | Date of Injury: | 09/01/2005 |
| Decision Date: | 02/03/2014 | UR Denial Date: | 10/02/2013 |
| Priority: | Standard | Application Received: | 10/11/2013 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in psychiatry is licensed to practice in California. 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 physician 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 patient is a 63 year old female with a date of injury of 9/1/2005. A review of the available clinical records indicates treatment for chronic psychological complaints and chronic musculoskeletal complaints in multiple body regions. Per the 9/4/13 evaluation submitted by ■■■■■, subjective complaints included ongoing depression, anxiety and poor sleep. No objective findings were submitted as part of the above progress report. Diagnoses included an adjustment disorder with anxiety and depression, insomnia resulting from a pain disorder, female hypoactive sexual disorder due to treatment has included multiple medications. At the time of the above evaluation, the patient was determined to be temporarily totally disabled. Under consideration are prospective requests for six psychotropic medication management sessions, Paxil, Ativan, Restoril and Atarax.

IMR ISSUES, DECISIONS AND RATIONALES

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

Paxil 20mg: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation adjustment disorder: epidemiology, diagnosis and treatment. Mauro Giovanni Carta, et al. Clin Pract Epidemiol Ment Health. 2009; 5: 15. Published online 2009 June 26 doi: 10.1186/1745-0179-5-15.

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

Decision rationale: Restoril is a benzodiazepine. According to the Chronic Pain Medical Treatment Guidelines 8 C.C.R. §§9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 24 of 127, Benzodiazepines 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. (Baillargeon, 2003) (Ashton, 2005). In this case it is clear that the prescriber [REDACTED] intended to keep the patient on Restoril longer than 6 weeks because the request for July Restoril was still being made in September. Due to guidelines stating use should be limited to six weeks, Restoril is not medically necessary. ❌

Atarax 25mg: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 405.

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, office visits, American Psychiatric Association Practice Guidelines, Practice Guideline for the Treatment of Patients With Major Depressive Disorder, Third Edition, DOI: 10.1176/appi.books.9780

Decision rationale: The CA MTUS does not specifically address office visits for psychiatric medication management. The ODG does address office visits as follows: ODG, Mental Illness & Stress, Office Visits. 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 American Psychiatric Association Practice Guidelines Practice Guideline for the Treatment of Patients With Major Depressive Disorder, Third Edition DOI: 10.1176/appi.books.9780890423387.654001 states the following with respect to therapeutic interventions: "b. Assessing the adequacy of treatment response In assessing the adequacy of a therapeutic intervention, it is important to establish that treatment has been administered for a sufficient duration and at a sufficient frequency or, in the case of medication, dose. Onset of benefit from psychotherapy tends to be a bit more gradual than that from medication, but no treatment should continue unmodified if there has been no symptomatic improvement after 1 month [I]. Generally, 4-8 weeks of treatment are needed before concluding that a patient is partially responsive or unresponsive to a specific intervention [II]." This reviewer notes that National standards of care require that the patient receives a minimum of six or more medication management session over a twelve month period in order to assess the efficacy of the medications such as Paxil, Ativan, Restoril and Atarax. Not only does this patient need two

medication management visits with a psychiatrist but will need ongoing psychiatric medication management visits with a psychiatrist over time for many reasons including but not limited to monitoring the patient for safety, efficacy of medications and monitoring for adverse effects such as increased suicidal ideation. Frequent visits would be needed to assess the patient's safety, overall condition and to monitor lab tests. In addition, the prescriber would need to collaborate with the entire health care team. Given the need to manage this complex set of medications superimposed upon the need to taper and eliminate Ativan and Restoril, this patient is clearly in great need of regular and ongoing psychiatric medication management. As such it is my opinion that the guidelines indicate that it is medically necessary in this case to have 6 MONTHLY PSYCHOTROPIC MEDICAL MANAGEMENT SESSIONS 1 PER MONTH FOR 6 MONTHS.