MAXIMUS Federal Services

Case Number:	CM14-0173333		
Date Assigned:	10/24/2014	Date of Injury:	12/28/2009
Decision Date:	12/03/2014	UR Denial Date:	10/10/2014
Priority:	Standard	Application Received:	10/20/2014

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 Colorado. 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:

42 year old female with date of injury 12/28/2009, continues follow up with treating physician. She has complaints of mid back pain, low back pain, and bilateral leg pains. Her diagnoses, per records supplied, include Lumbar Radiculopathy, Myofascial Pain, Severe Depression, and Sleep Disorder due to Pain. She has participated in multiple evaluations and therapies including Physical Therapy, massage, trigger point injections, nerve blocks, acupuncture, chiropractic care, TENS Unit, and HELP (Heath Education for Living with Pain) program for 6 weeks in 2013, with continuing remote HELP program since that time. The HELP program is documented as helpful to patient in the records supplied, and Physical Therapy notes provided also indicate patient progressing some in that area. None of the other interventions is discussed in detail or in outcomes in notes available for review. A Psychological assessment dated 3/25/2014 does address patient psychiatric conditions and verifies Severe Depression (Based on Beck Depression Inventory II score 37). The Psychologist performing patient assessment indicated Amitriptyline was helping patient sleep, but there is no clear indication in the records if Amitriptyline was given to the patient for sleep, pain, depression, or some combination thereof. Likewise, there is no indication in the record as to why Citalopram was started for patient, or when started. No further psychological assessment available in the records that were supplied for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ibuprofen 800 mg, for 30 days, 3 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 Treatment Guidelines Pain Interventions, and Treatments Page(s): 22 and 68.

Decision rationale: Per the Guidelines, Non-steroidal anti-inflammatory drugs are considered first-line therapy for short-term, symptomatic relief of low back pain, and recent clinical trials support the use in chronic low back as an effective measure. However, "a Cochrane review of the literature" indicates non-steroidal anti-inflammatory drugs are no more effective than Acetaminophen, opioids, or muscle relaxers in treatment of low back pain. The non-steroidal anti-inflammatory drugs, though, do have more documented side effects and adverse events than Acetaminophen and fewer side effects than opioids and muscle relaxers. There is insufficient evidence to recommend one non-steroidal anti-inflammatory drug over another. Per the Guidelines, no consistent, quality evidence exists to support the use of Non-steroidal anti-inflammatory drugs in neuropathic pain, but some evidence suggests they may be useful in breakthrough pain, or combination pain syndromes (nociceptive pain with neuropathic pain).Based on diagnoses in the records supplied, patient has a pain syndrome characterized by both nociceptive pain and neuropathic pain. The patient endorses some improvement in her pain with Ibuprofen, but outcome not quantified. (The pain ratings documented in the records vary from 5/10 to 10/10, and medications are not indicated as a factor in the change in pain levels.) The treating physician documented that the HELP program continues to assist patient in managing her chronic pain and he discussed functional goals to maintain, from the HELP program. (The HELP program notes were not specifically included in the records supplied, so the complete extent to which they have discussed / adjusted treatments and medications with patient is not known.) While the HELP program and Physical Therapy are mentioned in the notes as improving functionality, Ibuprofen is not mentioned with regard to function. As the records supplied do not quantify the effects of Ibuprofen on pain and/or function, and given the lack of evidence, per the Guidelines, to support long-term use of non-steroidal anti-inflammatory drugs in pain treatment, the request for Ibuprofen is not medically necessary.

Citalopram Hydrobromide 10 mg, #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chapter 15 Stress Related Conditions Page(s): 1098 and 1063,1066,Chronic Pain Treatment Guidelines Pain Interventions, and Treatments Page(s): 16.

Decision rationale: Per the ACOEM Guidelines, it is recommended to assess the chronic pain patient's psychological status, given the frequent coexistence of psychological disturbance in chronic pain. Valid clinic tools are required for screening, and can be accomplished with standard psychological assessment questionnaires. If the screening tests are positive for psychological disturbance or suggestive of underlying psychiatric disorder, then further

consultation with Psychologist or Psychiatrist is warranted. A clinical interview is also recommended, to be done in conjunction with the questionnaire, as it can help identify those at higher risk for psychological disturbance (history of substance abuse, previous psychiatric disorder, chronic physical concerns, failure to improve as expected)While it is common for primary care physicians and other non-psychology providers to evaluate and treat patients with psychiatric issues, per the ACOEM, more serious conditions, including severe depression and schizophrenia, should be referred to Psychiatrist or Psychologist for specialist evaluation and management. In the records supplied for review, the treating physician does not address psychological issues and does not document any discussion of patient progress with Amitriptyline and/or Citalopram. The treating physician notes also do not discuss these medications in the context of sleep or pain relief. The patient had Psychological evaluation with a Psychologist 3/25/2014; severe depression and sleep disorder due to pain diagnosed, and further psychological follow up and management recommended. (The evaluating Psychologist acknowledges the benefits to the patient of her remote HELP program and the benefits of Amitriptyline for sleep, but specifies that patient needs more than just that.) There is no indication in the records that patient ever-sought further evaluation or treatment with Psychologist / Psychiatrist. The treating physician documented at 8/21/2014 office visit increase in Citalopram to 20mg daily without any discussion or note made of why patient would need an increased dose. The dose then requested for UR after that appointment was still 10mg daily, so unclear, if patient having increased issues. The Guidelines clearly indicate that patients with severe psychological disturbance require specialist evaluation and management, and require monitoring of condition with follow up objective psychological assessments. As the records do not indicate that patient has been following up with specialist for her severe depression, and do not indicate that the treating physician has discussed her psychiatric issues / progress with her or assessed her status, the appropriateness of her current regimen cannot be determined. The request for Citalopram is therefore not medically indicated.

Amitriptyline HCL 25 mg, #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chapter 15 Stress Related Conditions Page(s): 1098 and 1063,1066,Chronic Pain Treatment Guidelines Pain Interventions, and Treatments Page(s): 13-14.

Decision rationale: Per the ACOEM Guidelines, it is recommended to assess the chronic pain patient's psychological status, given the frequent coexistence of psychological disturbance in chronic pain. Valid clinic tools are required for screening, and can be accomplished with standard psychological assessment questionnaires. If the screening tests are positive for psychological disturbance or suggestive of underlying psychiatric disorder, then further consultation with Psychologist or Psychiatrist is warranted. A clinical interview is also recommended, to be done in conjunction with the questionnaire, as it can help identify those at higher risk for psychological disturbance (history of substance abuse, previous psychiatric disorder, chronic physical concerns, failure to improve as expected)While it is common for primary care physicians and other non-psychology providers to evaluate and treat patients with

psychiatric issues, per the ACOEM, more serious conditions, including severe depression and schizophrenia, should be referred to Psychiatrist or Psychologist for specialist evaluation and management. While antidepressants can be effective in alleviating symptoms of depression, they can take weeks to reach peak efficacy, and can have side effects that adversely affect patient personal and professional life. Furthermore, if the initial diagnosis is incorrect, then antidepressants will not help. (Per the ACOEM, Incorrect diagnosis is the primary reason antidepressants are not effective.) Referral then for specialty evaluation and medication management is recommended if the diagnosis is in doubt or the psychological disturbance severe. Per the MTUS Guidelines, tricyclic antidepressants, such as Amitriptyline, are first line therapy in neuropathic pain and may have some efficacy in nociceptive pain as well. To determine if Amitriptyline is effective, patient evaluations should include discussion of pain levels, evaluation of function, discussion of changes in need for other analgesics, discussion of sleep quality, and psychological assessment. In the records supplied for review, the treating physician does not address psychological issues and does not document any discussion of patient progress with Amitriptyline and/or Citalopram. The treating physician notes also do not discuss these medications in the context of sleep or pain relief. The patient had Psychological evaluation with a Psychologist 3/25/2014; severe depression and sleep disorder due to pain diagnosed, and further psychological follow up and management recommended. (The evaluating Psychologist acknowledges the benefits to the patient of her remote HELP program and the benefits of Amitriptyline for sleep, but specifies that patient needs more than just that.) There is no indication in the records that patient ever-sought further evaluation or treatment with Psychologist / Psychiatrist. The Guidelines clearly indicate that patients with severe psychological disturbance require specialist evaluation and management, and require monitoring of condition with follow up objective psychological assessments. As the records do not indicate that patient has been following up with specialist for her severe depression, and do not indicate that the treating physician has discussed her psychiatric issues / progress with her or assessed her status, the appropriateness of her current regimen cannot be determined. The request for Amitriptyline is therefore not medically indicated.