

Case Number:	CM14-0090159		
Date Assigned:	07/23/2014	Date of Injury:	03/01/2014
Decision Date:	09/17/2014	UR Denial Date:	05/27/2014
Priority:	Standard	Application Received:	06/16/2014

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 Internal Medicine and is licensed to practice in New York. 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:

The claimant is a 65 year old male machinist who suffered an industrial injury on 03/01/2014 due to workplace harassment from his boss and superiors. His diagnoses include depression and anxiety. He is maintained on Prozac 20mg and has been evaluated by a psychiatrist. The treating provider has requested an evaluation for Transcranial Magnetic Stimulation and a Chiropractic referral.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transcranial Magnetic Stimulation: 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 Other Medical Treatment Guideline or Medical Evidence: Medscape Internal Medicine 2014; Transcranial Magnetic Stimulation Therapy.

Decision rationale: Transcranial magnetic stimulation (TMS) is a novel treatment for patients with major depressive disorder. Although clearly safer and better tolerated than many other pharmacotherapeutic options or electroconvulsive therapy, questions have persisted about the magnitude of the efficacy of TMS in patients with pharmaco-resistant depression, and the clinical

significance of these outcomes. Previous studies have explored whether specific patient characteristics are associated with a greater likelihood of clinical benefit. In the largest such analysis conducted to date, the authors confirmed previous observations that the lower the number of prior failed antidepressant treatments, the better the clinical outcome of treatment with TMS. This relationship between prior treatment resistance and subsequent treatment outcome is consistent with previous evidence from antidepressant studies. The efficacy of TMS demonstrated in randomized controlled trials was comparable to that of pharmaceutical antidepressants studied in similarly designed registration trials and to the adjunctive use of atypical antipsychotic medications in controlled trials of antidepressant non-responders. These data may be helpful in treatment-planning decisions when using TMS in clinical practice. Per the documentation the claimant has depression and a history of increased alcoholism (18 beers/day) and a history of physical abuse from his father. He has only been treated with Prozac 20mg per day. There is no documentation of other anti-depressants, alone or in combination; higher doses of Prozac, treatment for alcoholism, or any other non-medication therapy such as cognitive behavioral therapy. Medical necessity for the requested TMS has not been established. The requested item is not medically necessary.

Chiropractic Referral: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) and EBM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Chiropractic therapy.

Decision rationale: The claimant has complaints of bilateral shoulder and low back pain but there is no documentation of specific history, physical exam findings, and diagnoses. There is no specific indication for chiropractic therapy. Medical necessity for the requested service is not established. The requested service is not medically necessary.