

<b>Case Number:</b>	CM13-0061799		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	09/22/1984
<b>Decision Date:</b>	05/19/2014	<b>UR Denial Date:</b>	11/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/05/2013

### 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 Physical Medicine & Rehabilitation, and is licensed to practice in Illinois. 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 injured worker is a 72-year-old male with a date of injury of 09/22/1984; the mode of injury was not noted in the documentation provided. The injured worker has diagnoses of cervical degenerative disc disease, lumbar disc disease, neuropathy, hypertension, GERD and chronic renal disease. The injured worker was seen on 11/15/2013 for a follow-up appointment. The injured worker had a complaint of left ankle, knee, hip and low back pain. An examination was not documented on this date. Medication management was discussed and the patient's blood pressure and labs were checked. The physician noted to continue medications as directed and to follow-up in 1 month. The request was for Temazepam 30mg 1 QHS, Clonazepam 1mg BID, and Trazodone 50mg QID, a 3 month supply. The date and rationale of the request was not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TEMAZEPAM 30 MG, 1 QHS, A 3 MONTH SUPPLY VIA PMSI QTY 90: QTY 90:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines SECTION BENZODIAZEPINES.

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

**Decision rationale:** Temazepam is a benzodiazepine. The California MTUS guidelines indicate that 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. There was no documentation to show that the injured worker had a diagnosis of insomnia or was having any sleeping difficulties. The documentation provided in the clinical office note did not note any exceptional factors to show that medical necessity has been established. The clinical information provided for review did not indicate if this medication was a continuation or new medication. If this medication was a continuation it was not documented in the information for review how long the injured worker has been on this medication or the efficacy. Therefore, the request is non-certified.

**CLONAZEPAM 1 MG BID, A 3 MONTH SUPPLY VIA PMSI QTY 180: QTY 180:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines SECTION BENZODIAZEPINES.

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

**Decision rationale:** Clonazepam is a benzodiazepine. The California MTUS guidelines indicate that 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. Clonazepam is used for seizures and panic attacks. There was no documentation to show that the injured worker had a diagnosis of seizures or panic attack. The documentation provided in the clinical office note did not note any exceptional factors to support medical necessity. The clinical information provided for review did not indicate if this medication was a continuation or new medication. If this medication was a continuation it was not documented in the information for review how long the injured worker has been on this medication or the efficacy. Therefore, the request is non-certified.

**TRAZODONE 50 MG QID, A 3 MONTH SUPPLY VIA PMSI QTY 360: QTY 360:**  
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), SECTION MENTAL ILLNESS & STRESS.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), SECTION MENTAL ILLNESS & STRESS, TRAZODONE (DESYREL).

**Decision rationale:** The Official Disability Guidelines do indicate that trazodone is recommended as an option for the treatment of insomnia, only for injured workers with potentially coexisting mild psychiatric symptoms, such as depression or anxiety.

Improvements in sleep onset may be offset by negative next day effects, such as ease of wakening. Tolerance may develop. There was no documentation provided that the injured worker has any history of insomnia or any coexisting mild psychiatric symptoms, such as depression or anxiety. Also, in the documentation reviewed, there was no notation of functional improvement as a result of the use of this medication. As such, the medical necessity of trazodone has not been established. Therefore, the request is non-certified.