

<b>Case Number:</b>	CM14-0100090		
<b>Date Assigned:</b>	07/28/2014	<b>Date of Injury:</b>	03/17/2004
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	06/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2014

### 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 Psychiatry & Neurology, Addiction Medicine, has a subspecialty in Geriatric Psychiatry and 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 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 injured worker is a 52 year old female whose date of injury is 03/17/2004. Her primary diagnosis is 722.70 (intervertebral disc disorder with myelopathy). Her psychiatric diagnosis is major depressive disorder. Medically she has Type II diabetes. She experiences pain on full range of motion testing with her right shoulder being weaker than the left due to pain. She has decreased range of motion of the lumbar spine. Treatments recommended are medications and acupuncture. The patient continued her daily stretching and attested to walking in 20 minute intervals A PR2 of 05/08/14 reports that the patient's right shoulder and low back pain have increased, and that her medications (Tramadol, Relafin) are not working as well. Psychiatric follow up of 05/19/14 show that the patient attests to continued depression and anxiety, however feels "good" with her current combination of Abilify 15mg every morning, Cymbalta 60mg daily, and hydroxyzine 25mg three times per day as needed for anxiety, along with Xanax 0.5mg at bedtime as needed, which she uses 3-4 times per week at bedtime when she feels "stressed". She described that with her diabetes improving she feels more energetic and has been walking more. She denied suicidal ideation. A PR2 of 06/06/14 describes the same report almost verbatim. A psychiatric update report of 06/12/14 by [REDACTED] has the patient attesting to "feeling better", with good effect from her current "combo". Additional information documented that the patient was using her coping skills to reassure herself as she was still having negative dreaming. She was alert and oriented speech was soft and clear, good eye contact and focus, thoughts were linear. She wanted to be better. She does daily ADL's but takes longer than average. She was walking and receiving acupuncture. Medications at the time of this report were unchanged from those reported above. At least 1/6/14 10/13 Each sounds the same, no details Other than "stressed" no details or work up

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Xanax 0.5mg #20 with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary ; ODG formulary.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24 of 127.

**Decision rationale:** The patient reportedly uses Xanax 0.5mg at bedtime 3-4 times per week when "stressed". There is no description of what "stressed" really means. There is no evidence that her "stressed" condition at bedtime has been evaluated to discover the etiology of this complaint. Sleep disruption can be caused by a multitude of conditions such as pain, depression, anxiety, a situational stressor in one's life. The prudent practitioner would first attempt to treat nonpharmacologically (e.g. education regarding sleep hygiene). Medications would be prescribed based on which component of sleep disturbance the patient suffers from, e.g. sleep onset, maintenance, quality, and next-day functioning. and per records provided for review this has been prescribed since at least October 13. Benzodiazepines are recommended for short term use, she has been prescribed this medication since at least October 2013, which is well outside of CA-MTUS guidelines of 4 weeks. Therefore, based on guidelines and a review of the evidence, the request is not medically necessary. Per CA-MTUS 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.