

Case Number:	CM14-0155778		
Date Assigned:	09/25/2014	Date of Injury:	04/07/2010
Decision Date:	10/27/2014	UR Denial Date:	08/28/2014
Priority:	Standard	Application Received:	09/23/2014

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 Practice and is licensed to practice in Ohio. 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 male with a date of injury of April 7, 2010. His diagnoses include chronic post-traumatic stress disorder, anxiety, lumbar disc protrusions, and lumbar radiculopathy. He complains of chronic low back pain with radiation into the right hip that has been improving since having three epidural steroid injections. He also complains of anxiety, nightmares, and insomnia. An MRI scan from 2010 revealed multilevel bilateral neural foraminal narrowing, severe on the left at L5-S1. Electrodiagnostic studies from April 26, 2011 were normal. A recent utilization review had requested additional psychiatric notes to help substantiate diagnoses and clarify treatment plans. The records reviewed include two progress notes the last being from April 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 400MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anti-epilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs Page(s): 17.

Decision rationale: Anti-epilepsy drugs (AEDs) are also referred to as anti-convulsants. They are recommended for neuropathic pain (pain due to nerve damage). There is a lack of expert consensus on the treatment of neuropathic pain in general due to heterogeneous etiologies, symptoms, physical signs and mechanisms. Most randomized controlled trials (RCTs) for the use of this class of medication for neuropathic pain have been directed at postherpetic neuralgia and painful polyneuropathy (with diabetic polyneuropathy being the most common example). There are few RCTs directed at central pain and none for painful radiculopathy. The choice of specific agents reviewed below will depend on the balance between effectiveness and adverse reactions. See also specific drug listings below: Gabapentin (Neurontin); Pregabalin (Lyrica) A "good" response to the use of AEDs has been defined as a 50% reduction in pain and a "moderate" response as a 30% reduction. It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the "trigger" for the following: (1) a switch to a different first-line agent (TCA, SNRI or AED are considered first-line treatment); or (2) combination therapy if treatment with a single drug agent fails. After initiation of treatment there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. In this instance, there is documentation that there has been improved pain on the combination of gabapentin and two benzodiazepines but that the improvement in pain also seems temporally related to recent epidural injections. There is no real documentation to support increased functionality as a consequence of gabapentin. Because of the general lack of documentation, Gabapentin 400MG #30 is not considered medically necessary.

Temazepam 30mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Benzodiazepines

Decision rationale: Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of psychological and physical dependence or frank addiction. Most guidelines limit use to 4 weeks. Benzodiazepines are a major cause of overdose, particularly as they act synergistically with other drugs such as opioids (mixed overdoses are often a cause of fatalities). 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 (3-14 day). 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. Tolerance to lethal effects does not occur and a maintenance dose may approach a lethal dose as the therapeutic index increases. The best prevention for substance use disorders due to benzodiazepines is careful prescribing. Adults who use hypnotics, including benzodiazepines such as Temazepam, have a greater than 3-fold increased risk for early death, according to results of a large matched cohort survival analysis.

The risks associated with hypnotics outweigh any benefits of hypnotics. In this instance, it appears that the Temazepam is being used long-term as a sedative-hypnotic. There is no discussion in the documentation provided that other alternatives have been tried for insomnia. Per the above guidelines, Temazepam 30mg #30 is therefore not considered medically necessary. The treating physician should consult appropriate weaning guidelines or seek consultation with an addiction specialist for guidance.

Alprazolam 0.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain, Benzodiazepines

Decision rationale: Benzodiazepines like alprazolam are not recommended for long-term use because long-term efficacy is unproven and there is a risk of psychological and physical dependence or frank addiction. Most guidelines limit use to 4 weeks. Benzodiazepines are a major cause of overdose, particularly as they act synergistically with other drugs such as opioids (mixed overdoses are often a cause of fatalities). 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 (3-14 day). 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. Tolerance to lethal effects does not occur and a maintenance dose may approach a lethal dose as the therapeutic index increases. The best prevention for substance use disorders due to benzodiazepines is careful prescribing. In this instance, it appears that alprazolam is being utilized chronically for an anxiety disorder. There is no discussion from the notes about alternatives to benzodiazepines having been tried previously and there is no input from a psychiatrist available. Therefore, Alprazolam 0.5mg #60 is not medically necessary. The treating physician should consult appropriate weaning guidelines or consultant addiction professional for guidance.