

Case Number:	CM14-0173662		
Date Assigned:	10/24/2014	Date of Injury:	11/05/2010
Decision Date:	12/26/2014	UR Denial Date:	09/22/2014
Priority:	Standard	Application Received:	10/21/2014

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 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 67 year old male with a date of injury of 11-5-2010. He was involved in a rollover MVA with injuries to his head, neck, and psyche. The diagnosis given is major depressive disorder, recurrent with anxiety. The injured worker has been treated with a variety of anti-depressants and anti-psychotics but these were ultimately discontinued. He has been treated with escalating frequencies of Ativan 1mg, up to four times daily. He has been prescribed Restoril 30 mg at bedtime as needed for insomnia for several months. The notes from the treating physician state that the injured worker can sleep 5-6 hours a night but only with the assistance of sleep medication. A note from the utilization review physician notes at least 2 previous reviewer recommendations to taper and discontinue the Restoril. That has evidently not happened and there is no reference to these requests to taper within the body of the treating physician's notes. The injured worker has been noted on at least 2 occasions to admitting to taking daytime naps.

IMR ISSUES, DECISIONS AND RATIONALES

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

Restoril 30mg po q hs prn Insomnia #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepine/ Weaning of Medications Page(s): 24 & 124. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Insomnia Treatment and 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 (Chronic), Insomnia Treatment and Benzodiazepines

Decision rationale: Benzodiazepines such as Restoril 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. As for non-pharmacologic treatment of insomnia, empirically supported treatment includes stimulus control, progressive muscle relaxation, and paradoxical intention. Treatments that are thought to probably be efficacious include sleep restriction, biofeedback, and multifaceted cognitive behavioral therapy. Suggestions for improved sleep hygiene: (a) Wake at the same time every day; (b) Maintain a consistent bedtime; (c) Exercise regularly (not within 2 to 4 hours of bedtime); (d) Perform relaxing activities before bedtime; (e) Keep your bedroom quiet and cool; (f) Do not watch the clock; (g) Avoid caffeine and nicotine for at least six hours before bed; (h) Only drink in moderation; & (i) Avoid napping. In a head-to-head comparison of treatment approaches to determine separate and combined effects on insomnia, adding a prescription sleeping pill to cognitive behavioral therapy (CBT) appeared to be the optimal initial treatment approach in patients with persistent insomnia, but after 6 weeks, tapering the medication and continuing with CBT alone produced the best long-term outcome. These results suggest that there is a modest short-term added value to starting therapy with CBT plus a medication, especially with respect to total sleep gained, but that this added value does not persist. In terms of first-line therapy, for acute insomnia lasting less than 6 months, medication is probably the best treatment approach, but for chronic insomnia, a combined approach might give the best of both worlds; however, after a few weeks, the recommendation is to discontinue the medication and continue with CBT. Prescribing medication indefinitely will not work. The authors said that the conclusion that patients do better in the long term if medication is stopped after 6 weeks and only CBT is continued during an additional 6-month period is an important new finding. In this instance, there have been repeated recommendations to taper and discontinue the Restoril and yet the medication continues to be prescribed at the same frequency and dose. The medical records available for review do not discuss any cognitive behavioral treatment or a single recommendation regarding sleep hygiene. It is noted on a couple of different occasions that the injured worker takes daytime naps and still no recommendations to the contrary from the treating physician. The injured worker has been prescribed Restoril for a period of time that far exceeds recommendations from the referenced guidelines. Consequently, Restoril 30mg po q hrs prn Insomnia #30 is not medically appropriate or necessary.

