

<b>Case Number:</b>	CM14-0037116		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	04/24/2011
<b>Decision Date:</b>	08/11/2014	<b>UR Denial Date:</b>	03/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/26/2014

### 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 and 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:

Records reviewed include 68 pages of medical and administrative records. The injured worker is a 42 year old female whose date of injury is 04/24/11. Her diagnoses are depressive disorder and anxiety disorder not otherwise specified. She was employed as a manager at a residential association where she experienced job stress. A prior utilization review report shows that the patient said the association was having financial difficulties, and she subsequently became caught in a power struggle between the homeowners and the association board members. She stated that she suffered attacks, criticisms, was stalked and photographed, and placed under surveillance. All of this ultimately led to her being terminated from her position. She developed feelings of severe depression, anxiety, and panic attacks. Her initial psychological evaluation was on 10/26/11 by [REDACTED] (clinical neuropsychology) for a QME. She was on 3 antidepressants and two anti-anxiety medications (unknown). She had a prior history of being on psychiatric medications while at this same job in 2005. The patient was started on Viibryd, Lorazepam, and Latuda by [REDACTED] on 06/18/12, with Bupropion added in 12/12. The patient was complaining of increased anxiety and panic attacks. She had several changes made to her medication regimen including the addition of Neurontin, Effexor, Lamictal and Lunesta, as well as an increase of the Lorazepam to 1mg as needed. She has been in psychotherapy since at least July 2012. On 01/23/13 [REDACTED] reported that the patient was a little more optimistic but still very nervous, anxious, and depressed. She appears to have remained fairly stable for the remainder of the records provided for review. On 08/30/13 she was re-evaluated by [REDACTED] and he deemed her to be permanent and stationary. On October 24, 2013 [REDACTED] described her as seeming to be doing better overall. On 05/30/14, the patient was seen in follow up by [REDACTED], who noted that she remained anxious and

continued to need medication. He reported that they attempted to wean her off of the Ativan and change to Vistaril three times per day for anxiety. Despite [REDACTED] encouragement, the patient did not start the Vistaril as she was happy with her current medication. It should be noted that as early as 04/01/14 there was mention by [REDACTED] of the weaning from lorazepam, however there exists no elaboration in this regard. She denied thoughts of self harm or harm to others, there were no auditory or visual hallucinations, insight and judgment were good. She had no medication side effects such as akathisia or tremors. Current medications were Bupropion 150mg daily, Viibryd 40mg daily, and Lorazepam 0.5mg daily. [REDACTED] reported that the lorazepam was beneficial in decreasing the patient's anxiety and panic attacks. The patient denied having any panic attacks, but she attested to occasional hot flashes and racing pulse due to nightmares.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Lorazepam 0.5 mg:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The patient had been on Lorazepam since at least 06/12 and, from what I discern from [REDACTED] follow up visit documentation, she continued to suffer from a baseline state of depression and anxiety with episodes of increased anxiety. There was little mention of any improvement in her mood state until 10/13 when [REDACTED] described her as seeming to be doing better overall. On 04/01/14 he mentioned weaning her off of Lorazepam, and on 05/30/14 notes show that the patient was happy with her medications and did not begin the Vistaril that he encouraged her to start. 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. CA-MTUS clearly states that the long term use of benzodiazepines is not recommended for reasons stated below, with antidepressants recommended as a more appropriate treatment for anxiety. The patient was on the antidepressants Bupropion and Viibryd, apparently with minimal improvement in mood. A consideration might be given towards reassessing the current medication regimen, dosage, and efficacy. The fact that the patient is happy with her medication in and of itself is not a reason to continue providing a medication that is contraindicated. As such, this request for Lorazepam 0.5mg is not medically necessary.