

Case Number:	CM14-0091315		
Date Assigned:	09/12/2014	Date of Injury:	07/24/2012
Decision Date:	10/10/2014	UR Denial Date:	05/09/2014
Priority:	Standard	Application Received:	06/17/2014

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 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:

Injured worker is a 60 year old female with date of injury 7/24/2012. Date of the UR decision was 5/9/2014. Mechanism of injury was reported as work related stress. QME report dated 8/19/2014 suggested that the injured worker has been diagnosed and treated for Major Depressive Disorder, single episode, moderate and Generalized Anxiety Disorder. Psychological testing performed on 8/3/2014 suggested findings of mild depression at that time but she was experiencing hot sweats, anxiety. It was suggested that she was experiencing new problem of tardive dyskinesia in form of tongue rolling and lip smacking presumably as a side effect from Abilify which was discontinued because of the same reason in 01/2014. It was indicated that she has been undergoing regular psychotherapy; either individual or group. She was prescribed several psychotropic medications namely Nefazodone 100 mg at bedtime, Remeron 15 mg tab 1-2 tablets twice daily for depression, Lunesta 3 mg at bedtime for sleep and Clonazepam 1 mg up to 4 times a day for anxiety and Nuvigil 3-4 times per week for "energy". The documentation suggests that the injured worker has had problems with sleep medication abuse and had to have her stomach pumped once for the same.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lunesta 3mg #30: 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) Mental Illness & Stress (updated 4/9/14), Eszopicolone (Lunesta) and Insomnia Treatment

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, Insomnia Treatment

Decision rationale: ODG states " Non-Benzodiazepine sedative-hypnotics (Benzodiazepine-receptor agonists) are First-line medications for insomnia. This class of medications includes Zolpidem (Ambien and Ambien CR), Zaleplon (Sonata), and Eszopicolone (Lunesta). Benzodiazepine-Receptor Agonists Work by Selectively Binding to Type-1 benzodiazepine receptors in the CNS. All of the benzodiazepine-receptor agonists are schedule IV controlled substances, which mean they have potential for abuse and dependency. Eszopicolone (Lunesta) has demonstrated reduced sleep latency and sleep maintenance. (Morin, 2007) The only benzodiazepine-receptor agonist FDA approved for use longer than 35 days. A randomized, double blind, controlled clinical trial with 830 primary insomnia patients reported significant improvement in the treatment group when compared to the control group for sleep latency, wake after sleep onset, and total sleep time over a 6-month period. (Walsh, 2007) Side effects: dry mouth, unpleasant taste, drowsiness, dizziness. Sleep-related activities such as driving, eating, cooking and phone calling have occurred. Withdrawal may occur with abrupt discontinuation. Dosing: 1-2 mg for difficulty falling asleep; 2-3 mg for sleep maintenance. The drug has a rapid onset of action. (Ramakrishnan, 2007) " It also states "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. (Morin, 2009)" Lunesta is not indicated for long term treatment of insomnia as it has potential for abuse, dependency, withdrawal and tolerance. It has been indicated that she has had problems with sleep medication abuse needing intervention in form of pumping of the stomach. The request for continued use of Lunesta is not medically indicated. Thus, the request for Lunesta 3mg #30 is not medically necessary.

Clonazepam 1mg #100: 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, Weaning Of Medications Page(s): 24, 124.

Decision rationale: MTUS states "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. Upon review of the Primary Treating Physicians' Progress Reports, the injured worker has been prescribed Clonazepam long term for treatment of anxiety with no documented plan of taper. The MTUS guidelines state that the use of benzodiazepines should be limited to 4 weeks. Thus, the request for Clonazepam 1mg #100 is not medically necessary.