

Case Number:	CM14-0195822		
Date Assigned:	12/03/2014	Date of Injury:	05/10/1999
Decision Date:	01/16/2015	UR Denial Date:	11/12/2014
Priority:	Standard	Application Received:	11/21/2014

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 Psychiatry and Neurology, Addiction Medicine, has a subspecialty in Geriatric Psychiatry and is licensed to practice in California and Texas. 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 330 pages of medical and administrative records. The injured worker is a 56 year old female whose date of injury is 05/10/1999 related to a trip and fall injury, injuring her neck, back, right shoulder, bilateral wrists and hands, and left knee. She developed depression and anxiety. The primary diagnosis is brachial neuritis or radiculitis NOS. Psychiatric diagnoses are major depression, generalized anxiety disorder, and psychological factors affecting medical condition. Medically she suffers from Type II Diabetes, Thyroid condition, and Hypertension. She was treated with surgeries, Epidural Injections, physical therapy, supports/braces, pain management, weight management for obesity (several [REDACTED] treatments), and psychological therapy with medication management. An orthopedic evaluation of 04/29/09 details the patient's participation in the [REDACTED] program. When she began in 2006 her weight was around 277lbs, when she discontinued around Fall 2007 it was 236 lbs, and in 07/08 she was back up to 270 lbs, then 235 lbs in 04/09. After this her weight began to increase again. She received psychotherapy with biofeedback which was beneficial, and was prescribed Alprazolam, and Prozac (which she said caused temporary memory loss). On 10/23/14 the patient complained of inability to relax, pressure, chest pain, nausea, shortness of breath, excessive worry, restlessness, tension, depression, sleep disturbance, and lack of motivation. She was better able to concentrate, spent less time in bed, and felt less hopeless. Objective findings were visible anxiety, emotional withdrawal, tearfulness, and pressured. She was counselled regarding sleep hygiene. Medications prescribed were Lorazepam, Ambien, Cymbalta, and Topamax for headaches. On 11/13/14 an orthopedic re-evaluation reported multiple diagnoses of cervical strain with upper extremity radiculopathy, traumatic lumbar strain with intermittent left lower extremity radiculopathy, right shoulder contusion, right wrist tendinitis with carpal tunnel

syndrome due to walker use as a result of original fall, left wrist overuse syndrome, traumatic chondromalacia status post left knee arthroscopy, right knee strain, right 5th metacarpal fracture due to acute left knee instability, and left 3rd metatarsal bone fracture due to left knee instability. She was prescribed Omeprazole and naproxen, and Flexeril was refilled. A pain and addiction medicine PR2 of 11/13/14 indicated increased pain level of 9/10, sharp and severe. She was employed as a teacher's assistant. She was given Lidoderm film, Norco, Ibuprofen, Robaxin and Neurontin. On 12/01/14 [REDACTED] submitted a medication management evaluation. He noted that due to her stress-aggravated physical pain and disability she suffers from difficulty with daily activities and stress intensified medical complaints. She has damaged self-esteem, emotional withdrawal/mistrust, insufficient emotional control, and cognitive impairment with concentration/attention/memory deficits. Her medications interact to improve the above symptoms and removal could "tip the scale". The patient reported that Ativan reduces jumpiness, uneasiness, oversensitivity, and inability to relax, Cymbalta reduces agitation, Topamax eases pain and anxiety, Ambien assists sleep, her BAI=11 (mild range of depression), BDI=22 (moderate to severe range of subjective depression). Objectively she appeared anxious and disturbed, preoccupied with worry.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lorazepam 0.5mg #90 x 2 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness and Stress

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Antianxiety medications in chronic pain

Decision rationale: The patient has been prescribed Lorazepam 0.5mg TID since at least 10/23/14. This exceeds the recommended 4 week guideline. She has been diagnosed with generalized anxiety disorder (GAD). Although subjective and objective symptoms were given a Beck Anxiety Inventory was not provided. Benzodiazepines are effective for short term, but are not recommended as long term treatment for GAD. Other treatments approved for GAD are SSRIs, SNRI's (including Cymbalta, which she was already on), buspirone, etc. In addition, the patient is on opioid pain medications. These agents used in combination must be used with caution due to the potential for respiratory depression. This request is not medically appropriate. CA-MTUS: 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).ODG: Recommend diagnosing and controlling anxiety as an important

part of chronic pain treatment, including treatment with anxiety medications based on specific DSM-IV diagnosis as described below. Benzodiazepines are not recommended for longer than two weeks. Benzodiazepines are often used to treat anxiety disorders; however, many guidelines discourage the long-term use of benzodiazepines due to sedation effects and potential for abuse and psychological dependence. Long-term use is often associated with withdrawal symptoms. The request for Lorazepam 0.5mg #90 x 2 refills is not medically necessary.

Ambien 10mg #30 x 2 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Mental Illness and Stress

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress, Insomnia/Zolpidem

Decision rationale: The patient has been prescribed Ambien since at least 10/23/14. Guidelines recommend correcting deficit which are based on symptoms (e.g. sleep onset, maintenance, nonrestorative sleep), duration (acute or chronic), and etiology (primary or secondary to another condition such as comorbid medical or pain). It was identified that she had difficulty with sleep onset and maintenance but other conditions such as her diabetes, pain, and weight issues were taken into account, all factors effecting sleep. Stabilization of depression and anxiety as well effects sleep Zolpidem is recommended for short term use of two to six weeks only. This request is therefore, not medically appropriate. CA-MTUS does not reference Zolpidem. ODG was utilized in the formulation of this decision. Insomnia: Recommend correcting deficits, as nonrestorative sleep is one of the strongest predictors for pain. The request for Zolpidem is not medically necessary.

Topamax 25mg x 2 refills: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Topiramate for Migraine Prevention, American Headache Society 2012, John Wiley & Sons, doi:10.1111/j.1526-4610.2012.02161x

Decision rationale: The patient suffers from headache but she does not have the diagnosis of migraine disorder. Therefore this request is not medically indicated. The request for Topamax 25mg x 2 refills is not medically necessary.