

Case Number:	CM14-0203930		
Date Assigned:	12/16/2014	Date of Injury:	05/31/2005
Decision Date:	02/25/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	12/05/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Texas

Certification(s)/Specialty: Psychiatry, Geriatric Psychiatry, Addiction Psychiatry

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 64 year old female whose date of injury is 05/31/2005, the mechanism of which was not described. Orthopedic diagnoses include lumbar and cervical radiculopathy, lumbar spinal stenosis, and lumbar facet arthropathy. Treatments have been epidural injections, pain management, acupuncture, and TENS unit. Pain is described as 6/10 with medications, 8/10 without. ADL's are said to be limited. A PR2 of 10/17/14 from [REDACTED] office gives her the diagnoses of depressive disorder not otherwise specified and psychological factors effecting medical condition. The patient presented with depression, anxiety, and stress related to medical complaints. Subjectively she reported depression, sleep disturbance, lack of motivation, weight change, pessimism, agitation, difficulty thinking, and excessive worry. Objectively she was reportedly to be less depressed and irritable, was better able to concentrate, and with increased trust. Medications included Risperdal, Ambien, and bupropion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Risperdal One MG Q HS #30: 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 Mental Illness & Stress Atypical Antipsychotics

Decision rationale: The patient's subjective complaints are vague and nondescriptive. In the psychiatric community, an atypical antipsychotic might be added as an augmentation strategy for a patient who is not responding adequately to an antidepressant regimen. Rationale was not provided for the use of Risperdal in this patient, and documentation does not support its use. ODG does not recommend atypical antipsychotics as first line treatments. this request is therefore noncertified. Not recommended as a first-line treatment. There is insufficient evidence to recommend atypical antipsychotics (eg, quetiapine, risperidone) for conditions covered in ODG. See PTSD pharmacotherapy. Adding an atypical antipsychotic to an antidepressant provides limited improvement in depressive symptoms in adults, new research suggests. The meta-analysis also shows that the benefits of antipsychotics in terms of quality of life and improved functioning are small to nonexistent, and there is abundant evidence of potential treatment-related harm. The authors said that it is not certain that these drugs have a favorable benefit-to-risk profile. Clinicians should be very careful in using these medications. (Spielman, 2013) The American Psychiatric Association (APA) has released a list of specific uses of common antipsychotic medications that are potentially unnecessary and sometimes harmful. Antipsychotic drugs should not be first-line treatment to treat behavioral problems. Antipsychotics should be far down on the list of medications that should be used for insomnia, yet there are many prescribers using quetiapine (Seroquel), for instance, as a first line for sleep, and there is no good evidence to support this.

Ambien 10mg #15: 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 Mental Illness & Stress Insomnia Treatment

Decision rationale: Ambien is a nonbenzodiazepine agent used to treat insomnia. It is recommended for short term treatment, for 7-10 days. Clearly this patient has been receiving this medication for greater than the recommended time period. In addition, Ambien does not require tapering. This request is therefore noncertified. ODG Insomnia Treatment Recommend that treatment be based on the etiology, with the medications recommended below. See Insomnia. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. The specific component of insomnia should be addressed: (a) Sleep onset; (b) Sleep maintenance; (c) Sleep quality; & (d) Next-day functioning. See the Pain Chapter for detailed recommendations and references. Pharmacologic Treatment: There are four main categories of pharmacologic treatment: (1) Benzodiazepines; (2) Non-benzodiazepines; (3) Melatonin receptor agonists; & (4) Sedating antihistamines (primarily over-the-counter

medications).(1) Benzodiazepines: These medications are only recommended for short-term use due to risk of tolerance, dependence, and adverse events (daytime drowsiness, anterograde amnesia, next-day sedation, impaired cognition, impaired psychomotor function, and rebound insomnia). These drugs have been associated with sleep-related activities such as sleep driving, cooking and eating food, and making phone calls (all while asleep). Particular concern is noted for patients at risk for abuse or addiction. Withdrawal occurs with abrupt discontinuation or large decreases in dose. Decrease slowly and monitor for withdrawal symptoms. Benzodiazepines are similar in efficacy to benzodiazepine-receptor agonists; however, the less desirable side-effect profile limits their use as a first-line agent, particularly for long-term use.(2) Non-Benzodiazepine sedative-hypnotics (Benzodiazepine-receptor agonists): First-line medications for insomnia. Although direct comparisons between benzodiazepines and the non-benzodiazepine sedative-hypnotics have not been studied, it appears that the non-benzodiazepines have similar efficacy to the benzodiazepines with fewer side effects and short duration of action. Zolpidem [Ambien (generic available), Ambien CR, Edluar, Intermezzo] is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Longer-term studies have found Ambien CR to be effective for up to 24 weeks in adults.