

Case Number:	CM15-0102258		
Date Assigned:	06/04/2015	Date of Injury:	06/21/1998
Decision Date:	07/09/2015	UR Denial Date:	05/06/2015
Priority:	Standard	Application Received:	06/01/2015

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

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 64 year old female, who sustained an industrial injury on June 21, 1998. She reported low back pain. The injured worker was diagnosed as having status post excision of a large facet synovial cyst of the lumbar spine with persistent residual and left lumbar radiculitis, multilevel lumbar facet syndrome with spondylolisthesis and major depression. Treatment to date has included diagnostic studies, surgical intervention of the lumbar spine, conservative treatments, medications and work restrictions. Currently, the injured worker complains of low back pain, depression and insomnia secondary to pain. The injured worker reported an industrial injury in 1998, resulting in the above noted pain. She was treated conservatively and surgically without complete resolution of the pain. Evaluation on April 8, 2014, revealed continued pain as noted. It was reported she has been unable to return to work. Urinary drug screen noted benzodiazepine and was sent for quantitative studies. The plan was to continue medications, psychotherapy and a home exercise plan. Medications were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lunesta #30 with 2 refills: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Online Edition, Pain Chapter, 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) Pain Chapter/Insomnia Treatment Section.

Decision rationale: The MTUS Guidelines do not address pharmacologic sleep aids. Per the Official Disability Guidelines, pharmacological agents should only be used for insomnia management 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 whereas secondary insomnia may be treated with pharmacological and/or psychological measures. Eszopicolone (Lunesta) has demonstrated reduced sleep latency and sleep maintenance. It is 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. 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. Per the available documentation, the injured worker had been counseled on good sleep hygiene practices and has had no side effects from the use of Lunesta. It is unclear for what time period the injured worker has been taking Lunesta but it is clear that she is receiving relief of insomnia from its use. The request for Lunesta #30 with 2 refills is determined to be medically necessary.

Seroquel XR 50g #30 with 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 (ODG) Mental Illness & Stress, Atypical Anti-psychotics.

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 and Stress Chapter/Quetiapine Fumarate Section.

Decision rationale: MTUS guidelines do not address the use of Seroquil (quetiapine). Per ODG, Seroquil is not recommended as a first-line treatment. There is insufficient evidence to recommend atypical antipsychotics (eg, Quetiapine, Risperidone) for conditions covered in ODG. Seroquil is not FDA approved for use in patients with major depression or generalized anxiety disorder. The injured worker has been diagnosed with major depression and is followed by psychiatry. The request for Seroquel XR 50g #30 with 2 refills is determined to not be medically necessary.

Alprazolam 0.5mg #120 with 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 (ODG) Mental Illness & Stress Chapter, Antidepressants.

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

Decision rationale: The MTUS Guidelines do not support the use of benzodiazepines for long term use and is generally used no longer than 4 weeks, and states that a more appropriate treatment would be an antidepressant. The request for Alprazolam (Zanax) 0.5mg #120 with 2 refills is determined to not be medically necessary.