

Case Number:	CM14-0168549		
Date Assigned:	10/16/2014	Date of Injury:	04/17/2008
Decision Date:	11/18/2014	UR Denial Date:	09/30/2014
Priority:	Standard	Application Received:	10/13/2014

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, Neurology, and Addiction Medicine has a subspecialty in Geriatric Psychiatry and is licensed to practice in California, 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 545 pages of medical and administrative records. The injured worker is a 43 year old male whose date of injury is 04/17/2008. He worked in installation and repair of pumps and was loading thick sheets of heavy plywood onto a truck. One piece was misaligned, as he grabbed it, it yanked his right hand and he felt a twisting sensation in the right upper extremity. He has undergone multiple right shoulder surgeries, C6-C7 fusion, injections, conservative treatment, and pain management. He is not working currently. He has degenerative disk disease of the cervical and lumbar spines. He had a rotator cuff tear, adhesive capsulitis, and abnormal insertion of the biceps tendon with fraying and irregularity of the tendon at the insertion into the glenohumeral joint. He had right shoulder pain with decreased and painful range of motion and decreased strength. Psychiatrically he had been diagnosed with brief depressive reaction. He had panic attacks in 10/2013. He was prescribed Seroquel QHS. 02/07/13 psychiatric AME diagnosed the patient with depressive disorder NOS, pain disorder associated with psychological factors and general medical condition, and psychological factors affecting medical condition. He was anxious and having sleep issues. On 05/10/13 psychological re-evaluation shows that he did not want to try antidepressants. In a PR2 by [REDACTED] (psychiatrist) of 08/04/14, he prescribed Klonopin 1mg #60 at HS and discontinued Seroquel. [REDACTED] saw the patient again on 09/15/14. The patient felt that Klonopin 1mg was too strong, he had taken some of his mother's Xanax and felt that this helped him tremendously with sleep. The patient had tried Vistaril, Klonopin, Seroquel and a "sedating antidepressant" all with no effect on sleep. He was facing the possibility of surgery on his neck and shoulder. Mood was anxious and depressed, affect was bright, concentration fair, and there was no suicidal ideation. [REDACTED] reported on 09/18/14 that the patient felt stressed

and depressed, sleeping poorly, and grinding his teeth at night. He was taking meds but anger level was high, he felt alienated from family and worried about finances. Medications included Vicoprofen, Norco, Percocet, Metformin, and insulin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Xanax 1mg, QTY: 30 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain (Chronic)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress, Insomnia Treatment

Decision rationale: The patient complains of sleep disruption, however this is not well described in terms of phases of sleep (e.g. difficulty with sleep onset, midsleep awakening, etc). CA-MTUS and ODG both recommend against the use of benzodiazepines beyond 4 weeks. In addition, the use of benzodiazepines in a patient on multiple opioid pain medications run the risk of respiratory depression and should be approached with caution. ODG recommends nonbenzodiazepines as first line agents, the choice depending on the phase of sleep being treated (Ambien, Ambien CR, Lunesta, Sonata) for their more favorable side effect profile and shorter duration of action. It does not appear that these have been tried. Seroquel was apparently ineffective, as was an unnamed sedating antidepressant was also ineffective. It is unknown if Rozerem or over the counter agents (e.g. sedating antihistamines), or nonpharmacologic treatments (e.g. sleep hygiene education) were attempted. As such this request is noncertified. CA-MTUS does not reference benzodiazepines for use in insomnia. 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. ODG: 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. Sedating antidepressants (e.g., amitriptyline, trazodone, mirtazapine) have also been used to treat insomnia; however, there is less evidence to support their use for insomnia, but they may be an option in patients with coexisting depression. (3) Melatonin-receptor agonist: Ramelteon (Rozerem) is a selective melatonin agonist (MT1 and MT2) indicated for difficulty with sleep onset; is nonscheduled (has been shown to have no abuse potential). (4) Sedating antihistamines (primarily over-the-counter medications): Sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine [Benadryl, OTC in U.S.], promethazine [Phenergan, prescription in U.S., OTC in other countries]). Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. Non-

pharmacologic treatment: Empirically supported treatment includes stimulus control, progressive muscle relaxation, and paradoxical intention. Treatments that are thought to probably be efficacious include sleep restriction, biofeedback, and multifaceted cognitive behavioral therapy. Suggestions for improved sleep hygiene: (a) Wake at the same time everyday; (b) Maintain a consistent bedtime; (c) Exercise regularly (not within 2 to 4 hours of bedtime); (d) Perform relaxing activities before bedtime; (e) Keep your bedroom quiet and cool; (f) Do not watch the clock; (g) Avoid caffeine and nicotine for at least six hours before bed; (h) Only drink in moderation; & (i) Avoid napping.