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| <b>Case Number:</b>   | CM14-0216933 |                              |            |
| <b>Date Assigned:</b> | 01/06/2015   | <b>Date of Injury:</b>       | 01/17/2003 |
| <b>Decision Date:</b> | 02/28/2015   | <b>UR Denial Date:</b>       | 12/05/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 12/26/2014 |

### 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

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:

This 64 year old female sustained an industrial related injury on 01/17/2003 as the result of a fall in the parking lot. The results of the injury included injury to both knees, low back and neck. Per the progress report (PR) (12/03/2014), the injured worker's subjective complaints included lower back pain referred to the right side and difficulty sleeping due to pain. There were no objective findings or measurements in this report. An exam, performed on 11/18/2014, showed objective findings that revealed significant myofascial pain in the lumbar region with some muscle spasm noted, and significant decrease in range of motion (no specific values provided). Straight leg raise was positive (side not specified). Treatment to date has included physical therapy, medications, right knee arthroscopic surgery (2003 & 2013), cervical spine surgery (08/28/2013), right knee surgery (02/15/2013), injections to the knees, and conservative care. Recent diagnostic testing has included a MRI of the lumbar spine (09/19/2014) which revealed: L1-L2 facet degenerations; L2-L3 moderate posterior ligament and flavum hypertrophic changes with borderline stenosis; a 2-3 mm disc protrusion at L3-L4 with extension into both neuroforaminal exiting zone (moderate on the right and mild to moderate on the left) and noted neuroforaminal exiting zone compromise with borderline spinal stenosis; a 4-5 mm midline disc protrusion extending into both neuroforaminal exiting zones on the left resulting in moderate high-grade compromise and exiting nerve root with noted spinal stenosis; and a 2-3 mm disc protrusion at L5-S1 extending into both neuroforaminal exiting zones resulting in left neuroforaminal exiting zone compromise without spinal stenosis. Recent x-rays of the bilateral knees (09/30/2014) revealed: decreased medial joint space on the right with lateral femoral condylar spur on the left,

decreased left lateral joint space, an anvil spur at the anterior tibial plateau, and medial facet arthropathy bilaterally upon Merchant view. Current diagnoses include L4-L5 lumbar stenosis, referred right-sided radiculitis, cervical post-surgical syndrome, right knee status post medial meniscus tear, left knee rule out internal derangement, facet arthropathy, lumbar degenerative disc disease, and insomnia secondary to chronic pain. The Quazepam was requested for the treatment of insomnia. Treatments in place around the time the Quazepam was requested included current medications. The injured worker reported pain was increased without medications and decreased with medications. Limited current data was provided regarding functional deficits. Activities of daily living were improved with current medications. Work status was unchanged as the injured worker remained on temporary total disability. Dependency on medical care was unchanged. On 12/05/2014, Utilization Review modified a request for Quazepam 15 mg #30 which was requested on 12/01/2014. The Quazepam 15 mg #30 was modified to Quazepam 15 mg #15 based on the recommended short term use (usually 2 to 6 weeks) for the treatment of insomnia and the injured worker's improvement in sleeplessness. The MTUS Chronic Pain and ODG guidelines were cited. This UR decision was appealed for an Independent Medical Review. The submitted application for Independent Medical Review (IMR) requested an appeal for the modification of Quazepam 15 mg #30.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Quazepam 15mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 12 Low Back Complaints Page(s): 25-6, 291. Decision based on Non-MTUS Citation Schutte-Rodin S, Broch L, Buysse D, Dorsey C, Sateia M. Clinical Guideline for the Evaluation and Management of Chronic Insomnia in Adults. Journal of Clinical Sleep Medicine: JCSM: Official Publication of the American Academy of Sleep Medicine. 2008; 4(5): 487-504

**Decision rationale:** Quazepam (Doral, Dormalin) is a benzodiazepine derivative drug indicated for the short-term treatment of insomnia including sleep induction and sleep maintenance. Few, if any, long-term clinical trials extending beyond 4 weeks of chronic use have been conducted. Insomnia is defined as the subjective perception of difficulty with sleep initiation, duration, consolidation, or quality that occurs despite adequate opportunity for sleep, and that results in some form of daytime impairment. The non-MTUS guidelines for diagnosis, evaluation and treatment of insomnia published by the American Academy of Sleep Medicine is extensive but notes when using short-term benzodiazepines it should be followed with other longer use medications such as sedating antidepressants or other sedating agents. It also recommended use of behavioral and cognitive therapies to supplement any use of short-term hypnotics. The MTUS does not recommend long-term use of benzodiazepines. Review of the medical notes for this patient did not reveal a trial of longer use sedating medication coupled with use of Quazepam nor

the supplemental use of behavioral or cognitive therapies. The provider has not established medical necessity for continued use of Quazepam in this patient.