

Case Number:	CM14-0218162		
Date Assigned:	01/07/2015	Date of Injury:	10/18/2006
Decision Date:	03/30/2015	UR Denial Date:	12/02/2014
Priority:	Standard	Application Received:	12/30/2014

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: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 59 year old female, who sustained cumulative trauma injuries from 07/20/2004-10/18/2006. She has reported subsequent neck, back and upper and lower extremity pain and was diagnosed with cervical spinal stenosis with severe weakness and radiculopathy, thoracic discogenic pain and lumbar instability with severe weakness and severe nerve root compression. Treatment to date is unknown. The only medical documentation submitted is a progress note dated 07/07/2014. During this visit the injured worker was noted to report severe pain and weakness in the upper and lower extremities with loss of balance. Objective physical examination findings were notable for reduced range of motion in the lumbar and thoracic spine, shoulders, hands, wrists and elbows with tenderness. No documentation was submitted that pertains to the current treatment request. On 12/02/2014, Utilization Review non-certified requests for Prosom and Xanax, noting that these medications are not recommended for long term use. MTUS guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prosom, thirty count with two refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24 and 27.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines, Page(s): 24. Decision based on Non-MTUS Citation Insomnia treatment <http://www.odg-twc.com/index.html>

Decision rationale: According to ODG guidelines and in the treatment of insomnia section. 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. (Lexi-Comp, 2008) 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. Pharmacologic Treatment: There are four main categories of pharmacologic treatment: (1) Benzodiazepines; (2) Non-benzodiazepines; (3) Melatonin & melatonin receptor agonists; & (4) Over-the-counter medications. The majority of studies have only evaluated short-term treatment (i.e., 4 weeks) of insomnia; therefore more studies are necessary to evaluate the efficacy and safety of treatments for long-term treatment of insomnia. In 2007, the FDA requested that manufacturers of all sedative-hypnotic drugs strengthen product labeling regarding risks (i.e., severe allergic reactions and complex sleep-related behaviors, such as sleep driving). It is recommended that treatments for insomnia should reduce time to sleep onset, improve sleep maintenance, avoid residual effects and increase next-day functioning. (Morin, 2007) (Reeder, 2007) (1) Benzodiazepines: FDA-approved benzodiazepines for sleep maintenance insomnia include estazolam (ProSom), flurazepam (Dalmane), quazepam (Doral), and temazepam (Restoril). Triazolam (Halcion) is FDA-approved for sleep-onset insomnia. 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. According to MTUS guidelines, benzodiazepines are not recommended for long term use for pain management because of unproven long term efficacy and because of the risk of dependence. Most guidelines limit their use to 4 weeks. There is no recent documentation of insomnia related to pain. There is no rationale for combining ProSom with Xanax. Therefore the prescription of ProSom, thirty count with two refills is not medically necessary.

Xanax 0.5 g, sixty count with two refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24 and 27.

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

Decision rationale: According to MTUS guidelines, benzodiazepines are not recommended for long term use for pain management because of unproven long term efficacy and because of the risk of dependence. Most guidelines limit their use to 4 weeks. There is a report of anxiety and depression and the use and failure of antidepressant was not documented. Therefore the use of Xanax 0.5 g, sixty count with two refills is not medically necessary.