

Case Number:	CM15-0071505		
Date Assigned:	04/21/2015	Date of Injury:	11/15/2003
Decision Date:	05/22/2015	UR Denial Date:	03/31/2015
Priority:	Standard	Application Received:	04/14/2015

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: Pennsylvania
 Certification(s)/Specialty: Internal 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 59-year-old female sustained an industrial injury on 11/15/2003 due to a fall. Diagnoses include chronic cervical strain with spondylotic disc disease, chronic left sacroiliitis, contusions, chronic pain syndrome, chronic discogenic back pain with sciatica, lumbar radiculopathy and spinal stenosis, opioid dependence, alcohol dependence, depression, and anxiety. Medical history is also notable for chronic obstructive pulmonary disease (COPD) with nocturnal oxygen use. Evaluations include lumbar spine MRI dated 11/30/2011 and cervical spine MRI dated 12/6/2013. Treatment has included medications, heat, ice, activity modification, cervical and lumbar epidural steroid injections, biofeedback, physical therapy, and psychiatric treatment and therapy. Psychiatric reports note diagnoses of major depressive disorder and alcohol dependence. A remote hospitalization for benzodiazepine withdrawal was noted as was a rehabilitation stay for detoxification from narcotics in late 2008. A subsequent flare-up of back pain was noted to lead to relapse into excessive use of prescribed opioids and alcohol. In April 2014, the injured worker was admitted to the hospital for alcohol withdrawal syndrome/delirium tremens, with subsequent completion of a residential alcohol/drug treatment, depression control, pain management, and functional restoration program. A DUI and use of marijuana were noted. The physician who discharged the injured worker after treatment for these issues in 2014 noted she needs to continue complete opioid abstinence in the future regardless of any chronic pain (lower back) complaint. A hospitalization for suicidal ideation and relapse of alcohol use was noted in December 2014. Klonopin was prescribed at discharge with notation of a plan for taper, Seroquel was prescribed for insomnia and mood stability, and BuSpar was prescribed for

anxiety. A progress note of 1/17/15 documents noncompliance with medication with inappropriate random urine drug screen. It was noted that the incongruence of the urine drug screen with the medication list was discussed at length. Medications at that visit were noted to include Buspirone, Seroquel, Cymbalta, Prozac, docusate, Protonix, hydrocodone-acetaminophen, Methocarbamol, Clonazepam, thiamine, trazodone, Neurontin, Advair diskus, Albuterol, and vitamin B12. At a visit on 2/24/15, the injured worker reported ongoing pain in the low back and legs, rated 6/10 on average with a duration of years. Medications on that date did not include hydrocodone-acetaminophen. Physician notes dated 3/10/2015 show complaints of neck, low back, and bilateral leg pain rated 5/10. Medications included Buspirone, Seroquel, clonazepam, and additional medications. A new prescription for hydrocodone-acetaminophen was noted. An opioid agreement was noted. A letter on 3/12/15 from the physician who had treated the injured worker for detoxification to the current treating physician notes that the current treating physician has commenced prescriptions for both opiates (hydrocodone) and benzodiazepines (clonazepam), and states I am extremely concerned about resuming opiates and benzodiazepines for chronic pain in this case due to their lethal potential given her past problems with alcoholism, drug abuse, and depression. The letter goes on to note that opiates add to her risk of respiratory problems given her COPD. A visit with the current treating physician on 3/23/15 notes that the injured worker is seeing another physician for her psychiatric needs and that dose of Prozac and Paxil had been adjusted, and notes a recommendation for the psychiatrist to take over medications for depression and anxiety. On 3/31/15, Utilization Review non-certified requests for clonazepam 0.5mg #30, Buspirone 15mg #30, Seroquel 400mg #15, and hydrocodone/acetaminophen 5/325 #56, citing the MTUS and ODG.

IMR ISSUES, DECISIONS AND RATIONALES

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

Clonazepam 0.5mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines, Muscle Relaxants Page(s): 24, 66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter: benzodiazepines.

Decision rationale: Per the MTUS, benzodiazepines are 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. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. The MTUS states that a more appropriate treatment for anxiety disorder is an antidepressant. The MTUS does not recommend benzodiazepines for long-term use for any condition. The MTUS does not recommend benzodiazepines as muscle relaxants. The Official Disability Guidelines recommend against prescribing benzodiazepines with opioids and other sedatives. The injured worker has diagnoses of anxiety and depression. This injured worker was noted to have a history of benzodiazepine withdrawal, alcohol dependence, oxygen-dependent COPD, opioid addiction requiring detoxification, use of illegal drugs, and inconsistent urine drug screen. One of the

treating physicians noted that use of benzodiazepines in this case was potentially lethal, give the history as noted. Clonazepam (Klonopin) has been prescribed for several months recently, which is in excess of the guideline recommendation. Due to length of use in excess of the guidelines as well as high potential for toxicity in this injured worker given her history of prescription medication overuse and prior benzodiazepine withdrawal, the request for Klonopin is not medically necessary.

Buspirone HCL 15mg #30: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain, Chronic.

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: anxiety medications in chronic pain.

Decision rationale: The ODG states that diagnosing and controlling anxiety is an important part of chronic pain treatment, including treatment with anxiety medications. Buspar is approved for short-term relief of anxiety symptoms. Efficacy is decreased in patients with recent prior benzodiazepine use. In this case, the injured worker has a history of anxiety and depression as well as history of substance abuse, with contraindication to benzodiazepine anxiolytics for that reason. The documentation notes that she is under the care of a psychiatrist and notes longstanding issues with anxiety. These factors were not considered in the Utilization Review determination. As such, the request for Buspirone is medically necessary.

Seroquel 400mg #15: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 388. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) mental illness/stress chapter: Seroquel, atypical antipsychotics; pain chapter: anxiety medications in chronic pain.

Decision rationale: The ACOEM states that antidepressant or antipsychotic medication may be prescribed for major depression or psychosis, and that this is best done in conjunction with specialty referral. The ODG states that Seroquel is not recommended as a first line agent. Adding an atypical antipsychotic (such as quetiapine) to an antidepressant provides limited improvement in depressive symptoms in adults. This injured worker has a history of depression and anxiety, and current medications include Cymbalta and Paxil as well as Seroquel. It was documented that the injured worker is currently under the care of a psychiatrist. A complicated history including recent psychiatric hospitalization for suicidal ideation and history of substance abuse was documented. These contributing factors were not considered in the Utilization Review determination. As such, the request for Seroquel is medically necessary.

Hydrocodone Acetaminophen 5/325mg #56: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: This injured worker has a long history of substance abuse including alcohol abuse with hospitalization for delirium tremens, DUI, use of illegal substances, inconsistent urine drug screen, and multiple lengthy treatments for opioid overuse/addiction. A recent hospitalization for suicidal ideation and relapse of alcohol use was noted in December 2014. Concurrent use of alcohol or other illicit drugs is considered adverse behavior. Immediate discontinuation of opioids has been suggested for use of illicit drugs and/or alcohol. The MTUS notes that evidence of abuse or addiction would warrant consultation with a physician trained in addiction. MTUS also details indications for discontinuing opioid medication, such as serious non-adherence or diversion. The records clearly indicate inconsistent urine drug test and the inconsistent results are not explained by treating provider, which would be necessary for continued usage. The physician who supervised the treatment for opioid overuse and alcoholism in 2014 has noted that use of opiates may be potentially lethal for this injured worker, including risk of respiratory complications related to coexisting chronic obstructive pulmonary disease. Due to high risk of toxicity, history of substance abuse and addiction, and use of opioids not in accordance with the MTUS, the request for hydrocodone-acetaminophen is not medically necessary.