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Notice of Independent Review Decision

February 25, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Alprazolam oral tablets 0.5 mg, two month supply

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified Physical Medicine and Rehabilitation Physician

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

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PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who had first developed back pain in xxxx while mowing his yard. In xxxx, he strained his back again. The present episode developed in mid xx/xxxx.

2009: From February 18, 2009, through February 19, 2009, the patient was admitted. It was noted that the patient had developed back pain in xxxx while mowing his yard. He had full recovery of that problem after two epidural steroid injections (ESI). In xxxx, he strained his back again. The present episode developed in mid xx/xxxx. He developed more and more pain in the lower back

radiating down into the right leg with severe pain in the calf and numbness in the foot. Magnetic resonance imaging (MRI) of the lumbar spine had shown a large left-sided disc herniation at L5-S1. The diagnosis was large herniated nucleus pulposus (HNP) L5-S1 with left radiculopathy, low back pain and minimal bulging at L1-L2. M.D., performed left L5-S1 hemi-laminectomy with excision of HNP. After the surgery, the patient was seen by physical therapy (PT) to assist with progressive ambulation, mobility and strengthening. He described improvement in his back and leg pain and was ready for discharge by the afternoon of February 19, 2009. He was fitted with the lumbosacral corset for additional support and comfort.

2010: On August 31, 2010, performed a peer review. The following additional records were gathered from the peer review: **"**"*On December 11, 2009, evaluated the patient for back pain. The patient first sought treatment in January. MRI was done then. The patient was referred who performed back surgery on February 18, 2009. The patient was unable to follow through with physical therapy due to cost considerations. The patient was overall better; however, he reported he was still having left-sided back pain that radiated down the left leg. He was unable to work-out or run due to pain, left leg atrophy. The examination of the back showed no point tenderness and full range of motion. Neurological examination showed 5/5 strength in both lower extremities. Deep tendon reflexes were present but diminished on the left side compared to the right. Straight leg raise (SLR) was negative. Gait and station was normal. There was calf muscle atrophy on the left side compared to the right.*

In another examination dated January 11, 2010, attempts were made to use Mobic, Cymbalta, and Valium, but the patient only tolerated Mobic and Valium as needed.

On February 10, 2010, the patient was seen for followup of back injury. He continued to have pain in the left lumbar area, left piriformis, radiating down the left leg. History was positive for numbness below the waist in saddle distribution and pinching sensation at the end of his penis. The patient reported that this was occurring intermittently since April 2009. He had no bowel or bladder dysfunction. He was unable to return to work until he gets a full release. He felt that he was able to perform the physical aspects of his job. The patient was not tender on the lumbar paraspinal muscles at the SI joint or the piriformis area. Deep tendon reflexes were decreased in the left lower extremity compared to the right. There was left calf muscle atrophy. Sensory examination not performed. Diagnoses were back injuries xx/xxxx and xx/xxxx and status post lumbar surgery in February 2009 and chronic left lumbar pain. Treatment included Neurontin and Mobic. Follow-up in three months was recommended.

On February 16, 2010, MRI of the lumbar spine showed: Stable post surgical changes at L5-S1 with left laminectomy and scar, which surrounded the left S1 nerve root. There was no evidence of significant residual or recurrent disc disease. There was mild to moderate spinal canal stenosis at L4-L5 related to mild disc bulge and ligamentum flavum hypertrophy.

On June 23, 2010, MRI of the lumbar spine showed: Broad-based posterior disc bulge at L4-L5 producing mild overall canal stenosis, mild lateral recess stenosis and moderate lateral recess stenosis. There was broad-based posterior disc bulge at L5-S1 which was most prominent in the midline. There was epidural fibrosis compacting the S1 nerve root bilaterally, presumably post discectomy. There was evidence of advanced degenerative disc disease (DDD) at L5-S1. There was mild lateral recess stenosis at L1-L2. No significant change compared with February 16, 2010.

***On August 14, 2000**, MRI of the lumbar spine showed: Posterior osteophytes at the adjacent vertebral bodies of L5 and S1. There was disc bulging and narrowing at this level. There was lower intervertebral disc space dehydration. At L2-L3, there was normal neural canal and neural foramina. At L4-L5, there was disc bulging anteriorly and flattening of the thecal sac, there was stenosis due to hypertrophy of apophyseal facets. At L5-S1, there was encroachment of the neural foramina anteriorly from disc space and posterolaterally from the upper apophyseal facets. Neural foramina remained normal. Impression was mild spinal stenosis caused by a combination of disc space bulging and apophyseal facet hypertrophy. The neural foramina were patent."*

rendered the following opinions: (1) The clinical symptoms of low back pain spreading into the left leg were present and continuation of the initial injury of xx/xx/xx, was still present after the surgery in 2009. The patient apparently did return to work, but sustained a second injury with aggravation of the same symptoms to include pain in the low back spreading into the left leg. (2) The symptoms of second injury of low back pain spreading along the posterior aspect of the left leg into the calf were the same as in the initial injury of xxxx. The physical findings indicated objectively only the atrophy of the left calf. Otherwise SLR and range of motion (ROM) were normal. There were decreased reflexes in the left leg compared to the right. The impression would be postoperative simple discectomy L5-S1 on the left side post-laminectomy pain or neuropathic pain with postoperative scar at L5-S1 on the left side. The documents did not reveal the findings that were noted before surgery to make comparison of symptoms and findings with the postoperative clinical condition. The documentation and MRI diagnostic testing revealed changes noted after the initial injury, but no objective evidence of re-injury.

On September 7, 2010, in an addendum to the peer review opined as followed: (1) The only addition was that no objective findings were found by examination from xx/xx/xx, injury and the test showed postoperative changes with scar tissue. The midline posterior disc bulges at L4-L5 and L5-S1 were expected; because that portion of disc was not removed during surgery. The symptoms of second injury of the low back pain spreading along the posterior aspect of the left leg into the calf were the same as in the original injury of xxxx. The documents did not reveal the objective findings that were noted before surgery to make a comparison of symptoms and objective findings related to the postoperative clinical condition. The documentation revealed mostly subjective symptomatology and MRI

diagnostic testing revealed the changes already noted after the initial injury but again mostly subjective symptomatology without objective evidence of re-injury. (2) The treatment had been appropriate but prolonged from the injury sustained xx/xx/xx. The indications of surgery were added to the report as reflected by the ODG guidelines unless the described objective neurologic findings were encountered, the surgery was not indicated. If another operation was performed, it was likely on the same site of the surgical intervention on February 18, 2009, and therefore for the December 22, 2008, condition.

On December 20, 2010, evaluated the patient and reviewed the medical records and rendered the following opinion: There was an injury from the reported incident of xx/xx/xx. The history was complicated by overlapping incidents. The physician report of December 11, 2009, could be read as suggesting there was no new incident in xx/xxxx, or if there was one it was so minor as to not call attention to itself. But that physician's reports later discussed xx/xxxx injury in more detail. The medical evidence supported that an injury resulted from the xx/xx/xx, incident.

2011: Per an office visit note dated May 19, 2011, it was noted that the patient's complaints included persistent left leg pain/weakness and numbness. The evaluated noted that the patient had undergone ESI x3 and PT at BSA. He had temporary relief with ESI but PT made the symptoms worse. The patient had bladder dysfunction in the form of post void dribbling and erectile dysfunction (ED). The patient's current medications included alprazolam, Naprosyn, Norco, Flexeril and Neurontin. Diagnosis was chronic low back pain with left radiculopathy, HNP L5-S1 and L4-L5, epidural fibrosis on the left side at L5-S1 and anxiety secondary to the above mentioned diagnoses. Treatment plan was discussed. The patient was recommended lumbar MRI and re-exploration of left L5-S1. The handwritten record was partially legible.

On May 25, 2011, evaluated the patient for ongoing back complaints. The patient was previously seen on April 28, 2011, at which time medication changes were made. The patient reported that Neurontin made him feel outside of himself. The patient reported hydrocodone had helped with pain and alprazolam helped with anxiety. diagnosed lumbar pain with left lower extremity S1 radiculopathy and refilled medications to include Flexeril, Norco and Xanax. suspected that the patient would likely undergo another lumbar surgical procedure.

On August 15, 2011, performed decompressive lumbar laminectomy L4 and L5 with excision of HNP at L4-L5 and L5-S1 on the left, external neurolysis left L5-S1, bilateral lateral mass fusion L4 to the sacrum using laminar chip and ALLOSTEM, bilateral pedicle screws (EXPEDIUM screws) L4 to the sacrum. Postoperatively, the patient was fitted with chair-back brace. Physical therapist had seen him to assist with progressive ambulation and mobility. On the first morning of surgery, he had spasms in the lumbar spine as well as numbness into the right leg and genitalia consistent with nerve root swelling. His pain was not well controlled over the following couple of days. He continued to have numbness in the right groin and testicle and symptoms improved with administration of steroids. By August 18, 2011, he was ambulating well and was ready for

discharge. Incidentally, an MRI obtained on August 17, 2011, showed excellent positioning of the pedicle screws and no evidence of recurrent HNP, significant hematoma, etc. He reported being upset and depressed by that new problem with right leg and genitalia. The patient would be addressed as an out-patient for possible psychiatric consultation for depression. It was certainly complicated by the fact that he had chronic pain and had not been able to return to work since his original surgery in xxxx. The patient had been fully counseled regarding wound care and had received a back sheet for instructions. He was to wear the chair back brace at all times while out of the bed. He had prescriptions for pain medicine and muscle spasm and was to call if there were any problems.

Per an office visit note dated December 20, 2011, the patient had increased pain. He was doing very well at eight weeks. The patient's condition was discussed. The patient was recommended undergoing flexion and extension views of the lumbar spine. The patient was to discontinue Lortab and PT. The report is partially legible.

2013: On May 9, 2013, evaluated the patient for ongoing back complaints. The patient had pain in his lumbar spine and in the left leg with stiffness. He had pain in the mid and low back segments and pain which was worse in cold weather. prescribed Norco, Xanax, Flexeril and Naprosyn.

On July 2, 2013, performed a peer review. The following additional information was gathered from the peer review: "*The patient was seen as of September 10, 2010,. He had low back and leg pain. He had multiple studies including myelogram since his surgery. He had never had complete relief. His symptoms were worsening. He had persistent numbness in his left foot. A hemilaminectomy was done x 1. He had left calf atrophy. His neurological examination was intact though he had left pronounced weakness of dorsiflexion and plantar flexion. He had a positive straight leg examination. He had a diagnosis of spondylosis with myelopathy, intravertebral disc disorder with myelopathy lumbar region and degeneration of lumbar or lumbosacral intravertebral disc. MRI had showed narrowing of the canal on the left at L5-S1 and L4-L5. recommended left L4-L5 plus S1 progressive series and a home neural flossing exercise. He was given a prescription for tramadol and Robaxin and Naprosyn. The patient underwent a transforaminal ESI at L4-L5 plus S1 on September 15, 2010. A transforaminal ESI was done at S2 and L5-S1 on October 18, 2010. He was seen for an EMG/NCV study on October 20, 2010, showing a significant left S1 radiculopathy with no evidence of peripheral neurologic involvement in bilateral lower extremities. A designated doctor exam was done on September 28, 2010, with an MMI date of October 21, 2010, and 10% whole person impairment (WPI) rating by M.D. A lumbar ESI was done on 12/30/10. He was seen as of February 21, 2011, and his neurological exam showed left AJ at 0/4 and left EHL at 4/5 with partial foot drop. He was seen as of April 28, 2011, with left leg pain at BSA Family. It was noted he had lumbar pain with left lower extremity S1 radiculopathy, worse, pain was not controlled. He was currently treating with PT and medications. He was seen on May 25, 2011, at Medical Clinic. He had lumbar pain with left lower extremity S1 radiculopathy. He was given a refill of his*

medications. He was advised to follow-up. An MRI of the lumbar spine of June 9, 2011 showed progression of the L4-L5 disc pathology with mild left neural foraminal stenosis. Other levels remained stable. X rays of the lumbar spine showed DDD with disc space narrowing at L5-S1 on July 21, 2011. He underwent surgery as of August 15, 2011, with a decompressive lumbar laminectomy of L5 with excision of HNP L5-S1 on the left, recurrent and decompressive lumbar laminectomy of L4 with excision of HNP of L4-L5 on the left. Bilateral mass fusion of L4-L5 and L5-S1 utilizing laminar chips and Allostem and bilateral pedicle screw fixation supplementation at L4-L5 and S1 with intraoperative fluoroscopy for localization. Pathology report showed intervertebral disc excision (L4/-L5 and L5-S1). An MRI of the lumbar spine was performed on August 17, 2011, showing decompression of the central canal narrowing at L4-L5 status posterior spinal fusion and laminectomies from L4 to S1. No change in the bilateral moderate neural foraminal impingement at L4-L5. No change in findings at L5-S1. No changes in findings at L1-L2. He was seen in emergency room on xx/xx/xx, with acute right paresthesias post op. X-rays lumbar spine was performed on October 13, 2011, showing post-surgical changes from L4-S1, DDD at L5/S1 and loss of lumbar lordosis. On December 21, 2011, x-rays of the lumbar spine showed postoperative changes of fusion from L4 to S1 which appeared stable. MRI of the lumbar spine was performed on January 12, 2012, showing bilateral laminectomies at L4-L5 with epidural fibrosis at L4-L5 and L5-S1 and a small focal midline disc herniation at L5-S1 touching the anterior aspect of the thecal sac but with no deformity of the thecal sac or nerve roots. The "on" disc herniation was best seen on axial image 3 on series number 9. No disc herniation was noted at L4-L5. A small focal right-sided disc herniation was noted at L1-L2 it was unchanged. The patient was seen on January 31, 2012, for a new patient evaluation. His MMT was 5/5. He had no focal atrophy or fasciculations noted. His deep tendon reflexes were diminished in the left ankle and left knee. His sensory examination showed diminished sensation to pin in the distribution of L5 in the left lower extremity. His gait was normal. He had lumbar spine pain with left radiculopathy. He was given a prescription for Norco, Zonegran, Xanax and Doxepin. He was given IM Toradol. An ESI was recommended. An injection was performed of the left L5 neural foramina on February 16, 2012. On February 20, 2012, the patient continues to feel he had damage from the waist down and had spasm in his left leg. He had lumbar spine pain with left radiculopathy. He would like to have a trial of Dilaudid pump. On March 29, 2012, recommended an EMG study. He was seen by a pain management specialist on April 30, 2012. He had chronic pain syndrome, lumbar; post lumbar laminectomy/fusion of L4-L5 and L5-S1. He had radiculopathy at the left leg with left calf atrophy. recommended a psychological evaluation regarding appropriateness of Dilaudid intrathecal pump. The patient was seen on May 3, 2012, for an ESI. A physician pharmaceutical review was performed on June 14, 2012, with recommendations of weaning his prescription medications and referral to PRIDE program. On July 26, 2012, recommended a lumbar ESI. The patient was given prescriptions for Norco, Xanax, Flexeril and Naprosyn. On January 17, 2013, evaluated the patient for left leg pain and stiffness. He had pain in his mid and lower lumbar segments. She recommended a facet block. She noted his left leg was 42 Cm and the right was 44 cm. He was seen in emergency room with complaints of chronic low back pain

which was increasing noted on xx/xx/xx. He was admitted to the hospital on xx/xx/xx, for control of his chronic pain syndrome. His clinical examination showed that his neurological examination was intact. However, it was probably normal in the lower extremities. However, the patient was in too much pain to examine completely. He was admitted to the hospital and started on Robaxin, Decadron, Norco and Demerol IV. It was noted that he had extensive depression. recommended MHMR for evaluation by a psychiatrist for his depression. ESIs were also recommended. MRI of the lumbar spine was performed on March 6, 2013, showing extensive posterior fusion changes from L4 through S1 with total laminectomy. No evidence of residual or recurrent disc disease. Stable small posterior left paramedian disc extrusion at L1-L2. On March 13, 2013, noted pain in the lumbar spine and pain in the left leg and stiffness. His examination showed that he had pain in the lower lumbar segments and pain in the left sciatic notch. He had pain that radiated into the left lower extremity and atrophy of the muscles and left lower extremity. She recommended ESIs. He was given prescriptions for Norco, Xanax, Flexeril, Naprosyn and Butrans patch. On May 9, 2013, prescribed Norco, Xanax, Flexeril and Naprosyn.

opined as follows: (1) Based on the review of the records, the patient had ongoing chronic pain syndrome as it related to the work event from xx/xx/xx. He had post-laminectomy syndrome status-post fusion with evidence of reported calf atrophy and findings suggestive of radiculopathy, though his most recent MRI did not show an evidence of a residual or recurrent disc. (2) He had chronic pain syndrome and might have some addiction/tolerance to prescription medication. However, he reported findings of radiculopathy that was calf atrophy. (3) There had not been any significant progress from the current treatment including prescription medications and ESIs for any length of time. He had sought emergency room treatment/admission for control of his pain symptoms. (4) One would concur, with recommendations of weaning the patient's prescription medications and referral to a pain management program. The use of prescription medications and ESIs had not resulted in treatment of that condition or improvement of the patient's condition. The ESI recommendations had exceeded the ODG guidelines. (5) The repeat injections should be based on continued objective documented pain relief, decreased need for pain medications and functional response. It did not appear that the injections had resulted in such. (6) The use of Flexeril, a muscle relaxant, was not indicated on a continuous or chronic basis per the PDR. (7) In regard to the use of Xanax, the ODG noted that it was also not recommended on a chronic or continuous basis. (7) In regards to weaning of medications, weaning should have been done under the direction of the treating doctor and implementation of such should have been done under the direction of the treating doctor. (8) In regards to weaning of Flexeril, that should have been done under the direction of the treating doctor. There were no weaning protocols for the use of non-steroidal anti-inflammatory drug (NSAID) such as Naprosyn. An RME in the near future would be strongly recommended.

On July 3, 2013, prescribed Norco, Zanaflex, Flexeril and Naprosyn. The patient complained of anxiety. There was a psychiatrist that would take workers compensation in the area and the patient used the Xanax for anxiety.

On September 3, 2013, evaluated the patient for ongoing complaints. noted that postoperative PT led to leg burning. Hence, stopped it and sent the patient for ESIs. ESIs x2 resulted in temporary relief so that the patient returned to full activities and six to eight weeks later, all the symptoms recurred. Residual problem go along with workers compensation insurance denying further ESIs until he went to ER then they allowed him to only see who had been treating him with medications. diagnosed fusion of lumbosacral spine region, sacral and sacrococcygeal region radiculopathy, disorders of sacrum and neuralgia/neuritis and radiculitis, unspecified. He prescribed alprazolam, cyclobenzaprine, hydrocodone-acetaminophen and naproxen.

On October 2, 2013, evaluated the patient for chronic back pain, S1 radiculopathy and possible complaints of piriformis. noted that the Workman's Compensation System had recently made changes to their approved formulary and wanted the patient off the benzodiazepines. The patient had been on those for a long time and agreed that they should be stopped. recommended weaning tapering regimen from the following visit or the next visit. The prescribed alprazolam 0.5 mg, cyclobenzaprine 10 mg, hydrocodone-acetaminophen 10-325 mg and naproxen 500 mg.

On November 25, 2013, evaluated the patient for pain, erectile dysfunction, back injury, chronic back pain, atrophy, weakness, paresthesia, spasms, incontinence, lighting or shooting pain, anxiety due to pain and the run around the patient had gotten from Workman's Compensation System as a result of his injuries and insomnia. The patient was relegated taking medications in an attempt to alleviate his symptoms, but that was not very effective. He noted that he took the hydrocodone reported that it helped but did not make 100% of pain go away. The Flexeril also helped but did not make 100% of the muscle spasm and muscle pain to go away. The Xanax helped with anxiety and muscle, without it, he reported he was in continuous excruciating pain. The naproxen helped with the pain by reducing the inflammation. diagnosed sacral and sacrococcygeal radiculopathy and recommended repeating ESIs.

Per utilization review dated December 13, 2013, the request for alprazolam oral tablet 0.5 mg, two months supply was approved.

On December 30, 2013, noted that the patient had genuine back pain and all of its adverse sequelae. The patient had received a copy note of his last office visit when staff reported his abusive nature and there fear of his hostility then and going forward. decided to dismiss the patient from his practice. gave a new prescription with three reliefs of each of the four medications to include alprazolam 0.5 mg, cyclobenzaprine 10 mg, hydrocodone 10-325 mg and naproxen 500 mg.

2014: Per utilization review dated January 17, 2014, the request for alprazolam oral tablet 0.5 mg, two months supply was denied based on the following: "*The clinical documentation submitted for review does not support the continued use of*

alprazolam in this case. Although the most recent clinical record indicated that the patient was receiving relief from Xanax, it is clear that the patient has been assessed as physically dependent on Xanax. Furthermore the patient has been dismissed by the practice and it is unclear who at this time is responsible for prescribing alprazolam for this patient. Given the absence of any further clinical information from a new prescribing physician, this reviewer would not recommend certification for continued use of alprazolam at this time. While the requested medication does not meet medical necessity based on information presented it is expected that the ordering provider will follow recommended medication guidelines for safe discontinuation."

Per the reconsideration review dated January 29, 2014, the appeal for reconsideration of alprazolam oral tablet 0.5 mg, two months supply was denied based on the following rationale: "*Official Disability Guidelines states that alprazolam is not recommended for long term use. Most guidelines limit the use of benzodiazepines to 4 weeks. The documentation notes that the patient has been taking Alprazolam since October 2, 2013, which is well beyond the 4 week limit. At this time, if a weaning process has not already been initiated, per Official Disability Guidelines, in order for the patient to avoid dependence for the use of this medication weaning should be initiated. Therefore, at this time, the requested service cannot be warranted without objective documentation indicating that extended use is medically necessary due to extenuating circumstances. As such, the requested service is non-certified.*

In a letter dated February 11, 2014, the patient stated as follows: *"The within contained information is to show that the medication alprazolam is medically necessary and appropriate. Alprazolam has been a commonly used benzodiazepine used to treat anxiety. This medication cannot be started nor stopped without a doctor's supervision and approval. It is highly advised by my doctor, my pharmacist, and the manufacturer of the medication to not stop taking this mediation suddenly because of the increased risk of serious side effects. I have been taking this medication for several years. It has been deemed necessary and beneficial by four different treating doctors that were all approved by Workers' Compensation. My most recent treating doctor, has also been in agreement that this medication is medically necessary and appropriate. But due to the demands of the process and the Official Disability Guidelines book (not the Official Disability Gospel book) to approve this medication, the relationship between my doctor and I has been strained beyond repair. This entire situation only exacerbates my anxiety. I am trying to find a new treating doctor that will work with me to treat my condition and help me to obtain a better quality of life. My insurance adjuster has not been helpful in finding a new doctor. There are no doctors that take a Workers' Compensation case that is older than 90 days without reviewing a medical first. There is no guarantee that the doctor will see me. I am left driving a minimum of 2 hours or possibly 6+ hours. I cannot stop, continue, and/or adjust this medication as needed without a treating doctor. All I want is to be better and to have a good quality of life. This injury has taken so much from me and the insurance adjustor are only making a bad situation worse. This is a "legacy" case for them, but this is my life. I have to live with ever present*

pain everyday which causes subsequent anxiety. I am trying to learn how to cope day to day and don't need the constant setbacks that come with continued denials and fighting with the insurance adjuster just to get medically necessary medication approved. I am asking that you please review all my medical information and remember that I am just a person that was injured while working (twice) and am not just a case number."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Upon review of the available documentation, there is no appreciation of a formalized psychiatric assessment providing a diagnosis of Anxiety or recommendations for the use of alprazolam (a benzodiazepine). There is no report regarding failure of non-controlled prescription medications for the use of Anxiety. ODG Guidelines does not support the long term use of this medication, and in fact discusses the concern over increased risk versus benefit with benzodiazepine use: "Benzodiazepines are a major cause of overdose, particularly as they act synergistically with other drugs such as opioids (mixed overdoses are often a cause of fatalities)." "Adults who use hypnotics, including benzodiazepines such as temazepam, have a greater than 3-fold increased risk for early death, according to results of a large matched cohort survival analysis. The risks associated with hypnotics outweigh any benefits of hypnotics, according to the authors. In 2010, hypnotics may have been associated with 320,000 to 507,000 excess deaths in the U.S. alone. A dose-response effect was evident, with a hazard ratio of 3.60 for up to 18 pills per year, 4.43 for 18-132 pills per year, and 5.32 for over 132 pills per year. (Kripke, 2012)"

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES