

Case Number:	CM13-0015283		
Date Assigned:	12/27/2013	Date of Injury:	08/18/2000
Decision Date:	04/18/2014	UR Denial Date:	08/09/2013
Priority:	Standard	Application Received:	08/22/2013

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 Physical Medicine & Rehabilitation and is licensed to practice in 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:

The patient is a 70 year old male that reported an injury on 08/18/2000. The mechanism of injury was noted to be continuous trauma. The clinical note dated 10/21/2013 the patient complained of 8/10 pain with tingling in his hands. Neck pain that radiated to the upper extremities, mid back pain that was greater on the left than on the right, bilateral shoulder pain, headaches-two to three mild headaches that week, bilateral hand numbness and tingling, anxiety due to continued pain, difficulty sleeping due to pain. On the examination there was slight spasm of the paralumbar muscles, with active range of motion flexion was 80% of normal, and extension was 89% of normal. Spurling's sign is mildly positive to the right with scapular pain. There was mild tenderness and spasm from T1-T7. There was mild tenderness of the posterior upper shoulder region.

IMR ISSUES, DECISIONS AND RATIONALES

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

XANAX 0.5MG TWICE A DAY AS NEEDED FOR ANXIETY DUE TO CHRONIC PAIN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES Page(s): 24.

Decision rationale: The Expert Reviewer's decision rationale: The California MTUS does not recommend Xanax because it is a Benzodiazepine and they are not recommended for use of more than 4 weeks because there is a risk of dependence. Chronic benzodiazepines are the treatment of choice of very few conditions. They are known to have a rapid developing tolerance to their hypnotic effects. And long term use may increase anxiety. The clinical records did not show any objective symptoms of anxiety only a subjective complaint of anxiety. The request for Xanax is not recommended. Therefore the request is non-certified.

RESTORIL 15MG EVERY NIGHT #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES Page(s): 24.

Decision rationale: The Expert Reviewer's decision rationale: The California MTUS does not recommend Restoril because it is a Benzodiazepine and they are not recommended for use of more than 4 weeks because there is a risk of dependence. Chronic benzodiazepines are the treatment of choice of very few conditions. They are known to have a rapid developing tolerance to their hypnotic effects. And long term use may increase anxiety. The clinical records did not show any objective symptoms of anxiety only a subjective complaint of anxiety that was causing insomnia because of the chronic pain. The request for Restoril is not recommended. Therefore the request is non-certified.

INTERMEZZO 3.5MG #90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG).

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.

Decision rationale: The Expert Reviewer's decision rationale: Zolpidem (Intermezzo) is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. The documentation provided did not give subjective documentation on insomnia and since the request for Zolpidem is not recommended by the Official Disability Guidelines. Therefore the request is non-certified.