

Case Number:	CM13-0055494		
Date Assigned:	12/30/2013	Date of Injury:	07/15/2000
Decision Date:	06/30/2014	UR Denial Date:	10/29/2013
Priority:	Standard	Application Received:	11/21/2013

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 Psychiatry and is licensed to practice in California. 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:

Patient is a 44-year-old male who has submitted a claim for cervical myofascial pain, right knee strain/sprain, right knee lateral meniscal tear, s/p multiple right knee arthroscopies, s/p multiple falls allegedly from right knee pain resulting in right shoulder and left shoulder strains and contusion, right shoulder impingement syndrome from falls, right shoulder tear of the posterior inferior glenohumeral ligament and joint capsule, mild tendinosis of the supraspinous tendon, lumbar strain/sprain, mild degenerative disc disease, spondylosis L2-3 and L3-4 and major depression associated with an industrial injury date of 7/15/2000. Medical records from 2001-2013 were reviewed which revealed constant pain in the neck rated 9/10. Pain was described to be sharp and stabbing. There was also mid-back pain rated 8/10, which radiates to shoulder blade. Bilateral shoulder also has sharp pain graded 7/10. Low back pain was described to be stabbing which radiates down to the right leg and to the heel of the right foot. Both knee pain were graded 4/10 aggravated by doing activities of daily and relieved by intake of his pain medications. Physical examination showed tenderness in the bilateral cervical paraspinal muscles and superior trapezius muscles. No paravertebral muscle spasm noted. Bilateral shoulder has diffuse tenderness. There was decreased range of motion on the right shoulder. Neer and Hawkin tests were positive on the right shoulder and equivocal on the left. Examination of the lumbar spine showed tenderness in the lumbar paraspinal muscles. No spasm noted. Bilateral knee examination showed tenderness on the right knee including medial and lateral joint line. There was no significant peripatellar tenderness. Lachman, anterior drawer, posterior drawer and patellar compression tests were negative. No varus or valgus instability noted at 0 and 30 degrees of knee flexion. Treatment to date has included cervical epidural injections, physical therapy, and electrical stimulations, right knee surgeries done on 9/26/2000, 11/27/2001, 9/2/2003 and right shoulder surgery on 11/27/2000. Medications taken include Hydrocodone APAP, Paxil CR,

Lithium Carbonate ER, Ambien CR, Tegretol XR, Lisinopril, Lorazepam and Nexium. Utilization review from 10/29/13 modified the requests for Lorazepam 1 mg #120 and Ambien CR 12.5 mg #60 to 30 days supply. Requests were modified to allow weaning of both medications because Lorazepam and Ambien are not recommended for long-term use. 

IMR ISSUES, DECISIONS AND RATIONALES

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

AMBIEN CR 12.5MG, #60: Upheld

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

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, Zolpidem

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines, (ODG), Pain Chapter, Zolpidem was used instead. ODG states that Zolpidem is a prescription short acting non-benzodiazepine hypnotic, which is approved for short-term treatment of insomnia. In this case, the patient has been taking Ambien, brand name of Zolpidem as early as 10/18/2001. Medical records submitted did not mention patient's sleep hygiene. Therefore, the request for Ambien CR 12.5mg #60 is not medically necessary.

LORAZEPAM 1MG, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, , 23.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines 2009, Benzodiazepine, Page(s): 24.

Decision rationale: As stated on page 24 of the California MTUS Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because of unproven long-term efficacy and risk of dependence; use is limited to 4 weeks. In this case, the patient has been using Lorazepam, a benzodiazepine since at least 10/18/2001. However, long-term use is not recommended. In addition, there was no documentation stating functional improvement with the use of Lorazepam. There is no discussion concerning the need for variance from the guidelines. Therefore, the request for Lorazepam 1mg #120 is not medically necessary.