

Case Number:	CM13-0072488		
Date Assigned:	01/08/2014	Date of Injury:	02/23/2007
Decision Date:	06/13/2014	UR Denial Date:	12/18/2013
Priority:	Standard	Application Received:	12/31/2013

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 injured worker reported an injury on 02/23/2007. The mechanism of injury was not stated. Current diagnoses include herniated cervical disc with radiculopathy, right shoulder impingement syndrome with tendonitis, facet joint hypertrophy of the lumbar spine, symptoms of anxiety and depression, and symptoms of insomnia. The injured worker was evaluated on 09/13/2013. The injured worker reported 9/10 cervical spine pain with insomnia, anxiety, depression, and sexual dysfunction. Physical examination revealed limited cervical range of motion with 2+ spasm in the upper trapezius bilaterally. Treatment recommendations at that time included continuation of current medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

XANAX 0.5 MG QTY 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24, 66.

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

Decision rationale: California MTUS Guidelines state benzodiazepines are not recommended for long term use, because long term efficacy is unproven and there is a risk of dependence. Most

guidelines limit the use to 4 weeks. The injured worker does maintain diagnoses of anxiety and depression. However, California MTUS Guidelines state a more appropriate treatment for anxiety disorder is an antidepressant. The injured worker has utilized Xanax 0.5 mg since 04/2013 without evidence of objective functional improvement. Therefore, based on the clinical information received, the request for Xanax 0.5mg #60 is not medically necessary and appropriate.

PRILOSEC 20MG QTY 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: California MTUS Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients who have no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. There is no evidence of cardiovascular disease or increased risk factors for gastrointestinal events. There is also no frequency listed in the current request. Therefore, the request for Prilosec 20mg #30 is not medically necessary and appropriate.

AMBIEN 10 MG QTY 30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Work Loss Data Institute, Official Disability Guidelines (ODG) Treatment In Workers Compensation 5th Edition, Pain (Chronic) Zolpidem (Ambien).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Antiemetic.

Decision rationale: Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for the short term treatment of insomnia with difficult of sleep onset for 7 to 10 days. The injured worker has utilized Ambien since 04/2013. However, the injured worker continues to report difficulty sleeping. There is also no frequency listed in the current request. Therefore, the request for Ambien 10mg #30 is not medically necessary and appropriate.

REMERON 15 MG QTY 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

Decision rationale: California MTUS Guidelines state antidepressants are recommended for neuropathic pain, and as a possibility for non-neuropathic pain. There is no evidence of this injured worker's current utilization of this medication. There is also no frequency listed in the current request. Therefore, based on the clinical information received, the request for Remeron 15mg #30 is not medically necessary and appropriate.