

Case Number:	CM14-0011715		
Date Assigned:	02/21/2014	Date of Injury:	01/13/2010
Decision Date:	06/25/2014	UR Denial Date:	01/13/2014
Priority:	Standard	Application Received:	01/29/2014

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 Internal Medicine and Emergency Medicine, and is licensed to practice in Florida. 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:

This patient is a 57-year-old with a date of injury of January 13, 2010. A progress report associated with the request for services, dated November 1, 2013, identified subjective complaints of depression and insomnia. Objective findings only included the historical point that the patient has been taking the medications for 2 years. Diagnoses included major depression and insomnia. Treatment has included psychotropic medications. A Utilization Review determination was rendered on January 13, 2014 recommending non-certification of "monthly psychotropic medication management one (1) time per month for six (6) months; Celexa 20mg; Ativan 0.5mg; and Ambien CR 12.5mg".

IMR ISSUES, DECISIONS AND RATIONALES

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

MONTHLY PSYCHOTROPIC MEDICATION MANAGEMENT ONE (1) TIME PER MONTH FOR SIX (6) MONTHS: 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 MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, PAIN INTERVENTIONS AND TREATMENT, 11

Decision rationale: The Official Disability Guidelines (ODG) state that: "The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment." They note that patient conditions are extremely varied and that a set number of office visits per condition cannot be reasonably established. However, they do further state that necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self-care as soon as clinically feasible. The Medical Treatment Utilization Schedule (MTUS) state that there is no set visit frequency. It should be adjusted to the patient's need for evaluation of adverse effects, pain status, and appropriate use of medication, with recommended duration between visits from one to six months. The non-certification for follow-up was modified to one visit due to the lack of documentation of a treatment plan and response to therapy. One visit was authorized to allow an assessment that would then determine the need for further follow-up visits. Therefore, the medical record does not document the medical necessity for six monthly follow-up visits. Likewise, as noted in the Guidelines, ultimate independence from the health care system is the desired outcome. The request for monthly psychotropic medication management once monthly for six months is not medically necessary or appropriate.

ATIVAN 0.5MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, BENZODIAZEPINES,

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, BENZODIAZEPINES, 24

Decision rationale: Lorazepam (Ativan) is a benzodiazepine anxiolytic. The Medical Treatment Utilization Schedule (MTUS) state that 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 four weeks. They further note that that they are the treatment of choice in very few conditions. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. In this case, there is documentation of longer-term use. The request for Ativan 0.5 mg is not medically necessary or appropriate.

AMBIEN CR 12.5MG: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Ambien (zolpidem) is a non-benzodiazepine gamma-aminobutyric acid (GABA) agonist used for the short-term treatment of insomnia. The Medical Treatment Utilization Schedule (MTUS) does not specifically address zolpidem. The Official Disability

Guidelines (ODG) states that treatment of insomnia should be through correction of underlying deficits. They further note that zolpidem is indicated for short-term treatment of insomnia. They note that zolpidem has multiple side effects and adults who use zolpidem have a greater than 3-fold increased risk for early death (Kripke, 2012). Likewise, the FDA has recommended lower doses for IR release products in women (10 mg to 5 mg) and a decrease from 12.5 mg to 6.25 mg for extended-release products (Ambien CR). In this case, Ambien has been used beyond the short-term; likewise, at greater than recommended doses. The request for Ambien CR 12.5 mg at bedtime is not medically necessary or appropriate.