

<b>Case Number:</b>	CM14-0130938		
<b>Date Assigned:</b>	08/20/2014	<b>Date of Injury:</b>	08/01/2007
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	08/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/15/2014

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas & Ohio. 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 is a 46 year old female who reported an injury on 08/01/2007. The mechanism of injury was a fall. The injured worker had diagnoses of injury to the left knee and internal derangement of the left knee, major depressive disorder. Past medical treatment included medications and surgery. Diagnostic testing included x-rays and an MRI of the left. The surgical history included left knee status post arthroscopic and open incision date of surgery was not provided. The clinical note dated 05/10/2013 stated the injured worker had pain to knee with prolonged activity, with persistent popping to the knee. Physical exam on 05/10/2013 stated the injured worker antalgic gait to left knee with difficulty performing a squat test, and occasionally use of assistive device with left knee brace. The injured worker is rated with patellofemoral arthroplasty of left knee with a 15% impairment of the whole person per AMA guidelines. The injured worker had tenderness to left medial patellofemoral joint, and range of motion to left knee of 0-120 degrees. The clinical note dated 04/03/2014 was handwritten and largely illegible. The provider noted the injured worker complained of left knee pain, left arm pain, and increased rheumatoid symptoms. The injured worker was depressed and tearful. Medications included ambien, Ativan, flector patch, flexeril, naproxen, tramadol, vicodin ES 7, wellbutrin SR, and zantac. The treatment plan was not provided. The rationale for the request was not provided. The request authorization form was submitted 06/27/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ativan:** Upheld

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

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

**Decision rationale:** The 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 use to 4 weeks. The injured worker has been prescribed Ativan since at least 05/2013. The continued use of Ativan would exceed the guideline recommendation for a short course of treatment. There is a lack of documentation indicating the injured worker has significant objective improvement with the medication. The request for refills would not be indicated as the efficacy of the medication should be assessed prior to providing additional medication. Additionally, the request does not indicate the frequency at which the medication is prescribed, the dosage of the medication, and the quantity of the medication being requested in order to determine the necessity of the medication. As such, the request for Ativan is not medically necessary.

**Ambien:** 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), Zolpidem (Ambien).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Pain, Zolpidem (Ambien).

**Decision rationale:** The Official Disability Guidelines note zolpidem (Ambien) is a prescription short-acting non-benzodiazepine 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. It is recommended that treatments for insomnia should reduce time to sleep onset, improve sleep maintenance, avoid residual effects and increase next-day functioning. The injured worker has been prescribed Ambien since at least 05/2013. The continued use of Ambien would exceed the guideline recommendation for a short course of treatment. There is a lack of documentation indicating Ambien has provided a reduction in time to sleep onset, improved sleep maintenance, avoidance of residual effects and an increase in next-day functioning. The request for refills would not be indicated as the efficacy of the medication should be assessed prior to providing additional medication. Additionally, the request does not indicate the frequency at which the medication is prescribed, the dosage of the medication, and the quantity of the medication being requested in order to determine the necessity of the medication. As such the request is not medically necessary.