

Case Number:	CM14-0025591		
Date Assigned:	06/13/2014	Date of Injury:	07/21/2006
Decision Date:	07/25/2014	UR Denial Date:	02/27/2014
Priority:	Standard	Application Received:	02/28/2014

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 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:

The patient is a 52 year old female who suffered an injury on 7/21/06 while lifting a client which resulted in injuries to the spinal cord , low back, and mental which were accepted under her worker's comp claim. Pain treatment resulted in a drug addiction for high doses of Fentanyl and Opana, Norco and Vicodin but she voluntarily went through detox rx with a psychiatrist. Her diagnoses were cervical strain, T12 compression fx, DJD thoracic spine, disc protrusion at T7-8 and chronic pain , chronic myofascial pain syndrome, and opiate dependence. Her psychiatrist diagnosed her with depression and used cognitive behavior therapy. She was also diagnosed as having increased anxiety related to her pain. Her current regimen was Dilaudid 4 mg q 8 hours prn, biofreeze, and Ultram for her pain. She was also on Cymbalta 60 mg for depression, and Neurontin 400 mg at hs and Vistaril 25 mg bid for anxiety and panic attacks as well as Xanax .5 tid. Ambien CR 12.5 was prescribed for sleep. The patients PCP was denied auth for Nicotrol inhaler, Xanax and Ambien and IMR reviewed was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

NICOTROL INHALER 10MG, WITH 5 REFILLS #6: 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 Up to Date , online medical reference.Topic 16635 , Version 21.0.

Decision rationale: Nicotrol inhaler is a mouthpiece and plastic nicotine containing cartridge whose vapor deposits on the oropharynx and is absorbed through the buccal mucosa. It takes away the physical dependence for nicotine and has about 1/3 of the blood levels of nicotine that results from cigarette smoking. It is given for 6-12 weeks and then needs to be gradually titrated down for the next 6-12 weeks. It is considered a first line rx for tobacco dependence and is best used for breakthrough cravings in conjunction with a long acting nicotine patch. However , the patient's nicotine dependence is not related to her worker's comp injury and the carrier should not be expected to cover this service. This treatment should be pursued apart from her worker's comp claim.

AMBIEN DR 12.5MG, #30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Up to Date, Online Medical Reference Topic 16635, Version 21.0.

Decision rationale: Ambien is a medicine used to treat insomnia and most notably can cause CNS effects such as abnormal dreams, amnesia, anxiety, depression, and emotional lability. It can also cause such things as sleep walking or sleep driving. It is noted that sleep meds are not the first line treatment for insomnia. Sleep hygiene, behavioral techniques and possible CBT are first line treatments. Only after these are not fully efficacious should meds be started and at the lowest dose and the shortest period of time. In this patient we note that she is also on Neurontin 400 mg at HS and also Vistaril for anxiety at a dose of 25 mg BID. Prior to starting a new agent such as Ambien for sleep she should maximize the meds she is on. Her Vistaril is also utilized as a sleep agent and could be administered in a dose of 50 to 100 mg at hs. Her Neurontin is also sedating and could be increased to 600 to 800 mg at hs. Therefore, in this patient who has a H/O drug addiction in the past her medical regimen should be as simplified as possible and unnecessary meds should not be added. Therefore, Ambien is not indicated at this point in her treatment for insomnia.

XANAX .5MG, #90: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Up to Date Topic 14631 Version 22.0.

Decision rationale: Xanax is a benzodiazepine and used to treat anxiety in a dose of .25 to .50 TID. Adverse reactions are mostly CNS and include ataxia, depression, dizziness, fatigue, poor memory, and sedation. However, the most worrisome is habituation and addiction. It is not considered a first line treatment for anxiety. First line agents would be the SSRI's and if not effective the SNRI's. At times, a benzodiazepine is utilized in high doses temporarily while the SSRI's are taking effect but are rapidly titrated off when the antidepressant has reached its full effect. Other agents which are utilized for depression include tricyclics such as Imipramine and Vistaril. When the benzodiazepines are used to treat anxiety the patient should have minimal depression and no history of drug abuse. In this patient she is being treated with both low dose Vistaril , 25 mg bid and Xanax for her depression. She is also on Cymbalta. Prior to starting Xanax she should be tried on one of the SSRI meds such as Paxil. Also ,the Vistaril should be titrated up to a dose of possible 50 to 100 q6 hours as needed while the Paxil is achieving therapeutic blood levels. If Paxil were not successful the higher dose of Vistaril should be used prior to adding Xanax and dealing with 2 drugs with anxiety instead of just one. Also , the vistaril has less of a potential to cause side effects than Xanax. Therefore, Xanax is not indicated for treatment at this point.