

Case Number:	CM14-0081374		
Date Assigned:	07/18/2014	Date of Injury:	11/12/1996
Decision Date:	09/03/2014	UR Denial Date:	05/23/2014
Priority:	Standard	Application Received:	06/02/2014

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 Occupational 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 59 year old male who was injured on 11/12/1996. The mechanism of injury is unknown. Prior treatment history has included physical therapy. Prior medication history included amitriptyline HCl 25 mg tab, Mobic, Tizanidine, Medi-Derm cream. Progress report dated 05/09/2014 documented the patient to have complaints of acute low back pain. He rated his pain as 9/10 but improves with pain medicine. He reported he is able to perform activities of daily living with his medication. He stated his sleep is interrupted from the pain and is unable to concentrate, feeling anxious, and feeling depressed. On exam, there is trapezial tenderness. Range of motion is full and there is some upper extremity weakness in both hands. The hip revealed positive tenderness of the anterior hip. The assessment is degeneration of the lumbar intervertebral disc; occipital neuralgia, depression, TMJ disorder; insomnia; and trochanteric bursitis. The patient has been recommended to continue with Fioricet 50/325 mg; Terocin lotion 120; Norco 10/325 mg; and amitriptyline HCl. Prior utilization review dated Alprazolam 1mg, QTY: 120 is denied as it is not supported and 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:

Alprazolam 1mg, QTY: 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Alprazolam.

Decision rationale: This is a request for Alprazolam for a 59-year-old male injured on 11/12/96 with chronic low back pain, depression and insomnia. However, no rationale is provided for prescribing this medication. History and examination findings do not support use of this medication. Medical necessity is not established.