

Case Number:	CM15-0140224		
Date Assigned:	07/30/2015	Date of Injury:	06/29/2006
Decision Date:	09/01/2015	UR Denial Date:	07/13/2015
Priority:	Standard	Application Received:	07/20/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New York
 Certification(s)/Specialty: Anesthesiology

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 48 year old female, who sustained an industrial injury on 6-29-06. The mechanism of injury is not documented. The injured worker was diagnosed as having complex regional pain syndrome of right lower extremity, spondylolisthesis L5-S1, 50% loss of disc space height L5-S1, lumbar radiculopathy and Reflex Sympathetic Dystrophy Syndrome of right arm and right leg. Treatment to date has included physical therapy, acupuncture, chiropractic treatments, injections, surgery and oral medications including Klonopin 1mg, Xanax 1mg, Prochlorperazine 10mg, Fioricet 50-350mg, Ambien 10mg, Oxycodone 15mg and OxyContin 40mg. Currently on 6-11-15, the injured worker describes ongoing difficulty with pain in her head, neck, right upper extremity, mid back, low back, right leg and left leg from the knee to the ankle. She rates her pain level as 10 out of 10 and reduced to 7-10 with medications. She recently went one week without medications when they were not approved. She notes she begins to experience relief within 45 minutes of taking medication and the relief lasts for approximately 3 hours; pain level is rated between 5-10 and 10-10 and described as burning, aching, throbbing, tingling, tightness, spasms, numbness, tenderness swelling, weakness, hypersensitivity and pressure. Physical exam performed on 6-11-15 revealed frank difference in coloration between hands with right hand cooler to touch. The treatment plan included refilling of Klonopin 1mg, Xanax 1mg, Prochlorperazine 10mg, Fioricet 50-350mg, Ambien 10mg, Miralax Powder 17gm, Oxycodone 15mg and OxyContin 40mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Xanax 1mg #240: 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: According to CA MTUS Guidelines, benzodiazepines are not recommended for long-term use for the treatment of chronic pain because long-term efficacy is unproven and there is a risk of dependency. Xanax (Alprazolam) is a short-acting benzodiazepine, having anxiolytic, sedative, and hypnotic properties. Most guidelines limit use of this medication to four weeks. The documentation indicates the patient has depression and anxiety. The guidelines recommend that a more appropriate treatment for an anxiety and depression disorder would be an antidepressant. There is no documentation provided indicating that the patient is maintained on any antidepressant medication. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

Ambien 10mg #120: 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 Official Disability Guidelines (ODG) Mental-stress, Ambien.

Decision rationale: Ambien (Zolpidem) is a prescription short-acting non-benzodiazepine hypnotic, which is recommended for short-term treatment of insomnia (two to six weeks). Ambien is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Longer-term studies have found Ambien CR to be effective for up to 24 weeks in adults. This can be habit-forming, and may impair function and memory more than opioid analgesics. There is also concern that Ambien may increase pain and depression over the long-term. The treatment of insomnia should be based on the etiology, and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. In this case, Ambien has been used for greater than 6 months. There is no documentation provided indicating medical necessity for Ambien. The requested item is not medically necessary.