

Case Number:	CM15-0192180		
Date Assigned:	10/06/2015	Date of Injury:	02/09/2009
Decision Date:	11/18/2015	UR Denial Date:	09/18/2015
Priority:	Standard	Application Received:	09/29/2015

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: California
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 was a 53year old female, who sustained an industrial injury, February 9, 2009. The injured worker was undergoing treatment for degenerative depressive disorder, insomnia, psychological factors affecting medical condition. According to progress note of July 1, 2015, the injured worker's chief complaint was low back pain, bilateral lower extremity pain and bilateral lower extremity numbness with occasional mid back pain symptoms. The physical exam noted full range of motion of the thoracic and lumbar spine. There was tenderness with palpation of the lumbar spine. The motor and sensation were intact the lumbar and thoracic spine. The injured worker previously received the following treatments EMG and NCS (electrodiagnostic studies and nerve conduction studies) of the bilateral lower extremities was normal on July 1, 2015. The RFA (request for authorization) dated July 1, 2015, the following treatments were requested prescriptions for Ativan 2mg #90, Ambien CR 12.5mg #30 and Xanax 0.25mg #30. The UR (utilization review board) denied certification on September 18, 2015; for the prescriptions for Ativan 2mg #90, Ambien CR 12.5mg #30 and Xanax 0.25mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ativan 2 MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

Decision rationale: Based on the 08/21/15 progress report provided by treating physician, the patient presents with low back pain radiating to right leg. The request is for ATIVAN 2 MG #90. Patient's diagnosis per Request for Authorization form dated 07/01/15 includes severe major depressive disorder with psychotic features. Diagnosis on 06/24/15 included insomnia type sleep disorder due to pain and psychological factors affecting medical condition. Physical examination on 08/21/15 revealed decreased sensation of the L5 and S1 on the right with positive straight leg raise. Treatment to date has included imaging and electrodiagnostic studies, physical therapy, chiropractic, epidural injection and medications. Patient's medications include Zoloft, Ativan, Ambien, Xanax and Atarax. Patient's work status not provided. MTUS Guidelines page 24 states 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 4 weeks." Ativan has been included in patient's medications per progress reports dated 06/24/15 and 11/25/14. It is not known when this medication was initiated. Per 06/24/15 report, treater states "...the functional benefit with medication management and medication(s) is the patient has been better able to execute functions of daily living. The benefit of month to month psychotropic medication management allows for the doctor and the patient to address any changes and monitor effectiveness of the medication(s). It is essential that they continue taking medications as prescribed to prevent regression." However, guidelines do not recommend long-term use of benzodiazepines. The patient has been prescribed this medication at least since 06/24/15, which is not in accordance with guidelines. Therefore, the request IS NOT medically necessary.

Ambien CR 12.5 MG #30: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, under Zolpidem.

Decision rationale: Based on the 08/21/15 progress report provided by treating physician, the patient presents with low back pain radiating to right leg. The request is for AMBIEN CR 12.5 MG #30. Diagnosis on 06/24/15 included insomnia type sleep disorder due to pain and psychological factors affecting medical condition. Physical examination on 08/21/15 revealed decreased sensation of the L5 and S1 on the right with positive straight leg raise. Treatment to date has included imaging and electrodiagnostic studies, physical therapy, chiropractic, epidural injection and medications. Patient's medications include Zoloft, Ativan, Ambien, Xanax and Atarax. Patient's work status not provided. Official Disability Guidelines, Pain Chapter, Zolpidem (Ambien) Section states: Zolpidem is a prescription short-acting nonbenzodiazepine hypnotic, which is recommended for short-term 7-10 days treatment of insomnia. Proper sleep

hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. Ambien has been included in patient's medications per progress reports dated 09/24/14, 11/25/14, and 06/14/15. It is not known when this medication was initiated. Per 06/24/15 report, treater states "the functional benefit with medication management and medication(s) is the patient has been better able to execute functions of daily living...The benefit of month to month psychotropic medication management allows for the doctor and the patient to address any changes and monitor effectiveness of the medication(s). It is essential that they continue taking medications as prescribed to prevent regression." The patient has been prescribed Ambien at least since 09/24/14. While this patient presents with chronic pain and insomnia, ODG does not support the use of this medication for longer than 7-10 days. Furthermore, the request for additional 30 tablets does not indicate intended short-term use of this medication. This request is not in accordance with guidelines. Therefore, the request IS NOT medically necessary.

Xanax .25 MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter, under Xanax.

Decision rationale: Based on the 08/21/15 progress report provided by treating physician, the patient presents with low back pain radiating to right leg. The request is for XANAX .25 MG #30. Diagnosis on 06/24/15 included insomnia type sleep disorder due to pain and psychological factors affecting medical condition. Physical examination on 08/21/15 revealed decreased sensation of the L5 and S1 on the right with positive straight leg raise. Treatment to date has included imaging and electrodiagnostic studies, physical therapy, chiropractic, epidural injection and medications. Patient's medications include Zoloft, Ativan, Ambien, Xanax and Atarax. Patient's work status not provided. MTUS Guidelines page 24 states, "benzodiazepines are not recommended for long-term use because long-term efficacies are unproven and there is a risk of dependence." ODG-TWC, Pain (Chronic) Chapter, under Xanax (Alprazolam) states: "Not recommended for long-term use. See Alprazolam; & Benzodiazepines. Alprazolam, also known under the trade name Xanax and available generically, is a short-acting drug of the benzodiazepine class used to treat moderate to severe anxiety disorders, panic attacks, and as an adjunctive treatment for anxiety associated with major depression." Xanax has been included in patient's medications per progress reports dated 09/24/14, 11/25/14, and 06/14/15. It is not known when this medication was initiated. Per 06/24/15 report, treater states "...the functional benefit with medication management and medication(s) is the patient has been better able to execute functions of daily living...The benefit of month to month psychotropic medication management allows for the doctor and the patient to address any changes and monitor effectiveness of the medication(s). It is essential that they continue taking medications as prescribed to prevent regression." However, guidelines do not recommend long-term use of benzodiazepines. The patient has been prescribed this medication at least since 09/24/14, which is not in accordance with guidelines. Therefore, the request IS NOT medically necessary.

