

<b>Case Number:</b>	CM15-0036735		
<b>Date Assigned:</b>	03/05/2015	<b>Date of Injury:</b>	08/17/2010
<b>Decision Date:</b>	04/14/2015	<b>UR Denial Date:</b>	02/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/26/2015

### 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, West Virginia, Pennsylvania  
 Certification(s)/Specialty: Emergency Medicine

### 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 57 year old male who sustained an industrial injury on 8/17/10. The injured worker reported symptoms in the back. The diagnoses included chronic pain syndrome. Treatments to date include oral pain medication and activity modification. In a progress note dated 12/15/14 the treating provider reports the injured worker was with "lumbar spine muscle spasm, range of motion: moderate pain with motion." On 2/18/15 Utilization Review non-certified the request for Ambien 5 milligrams, Ambien 10 milligrams, modified the request for Hydrocodone 10 milligrams Acetaminophen 325 milligrams to hydrocodone 10/325 milligrams 2 tablets per oral every 8 hours and modified the request for Ativan 1 milligram to Ativan 1 milligrams one tablet per oral every 8 hours as needed 90 tablets. The MTUS, ACOEM Guidelines, (or ODG) was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien 5mg:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Pain Chapter) FDA (Ambien).

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

**Decision rationale:** Guidelines recommend Ambien for short term treatment of insomnia. In this case, there is no documentation of insomnia, no indication of efficacy and no indication for chronic use of Ambien. In addition, the records indicate that there is a recommendation to stop Ambien. Thus the request for Ambien 5 mg is not medically necessary and appropriate.

**Ambien 10mg:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Pain Chapter) FDA (Ambien).

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

**Decision rationale:** Guidelines recommend Ambien for short term treatment of insomnia. In this case, there is no documentation of insomnia, no indication of efficacy and no indication for chronic use of Ambien. In addition, the records indicate that there is a recommendation to stop Ambien. Thus the request for Ambien 10 mg is not medically necessary and appropriate.

**Hydrocodone 10mh-Acetaminophen 325mg:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioid Page(s): 78-81.

**Decision rationale:** Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner, taken as directed, prescribed at the lowest possible dose and there is ongoing monitoring for efficacy, side effects, functional status and aberrant use. In this case, clinical records do not document efficacy, functional benefit, pain contract, or other monitoring for chronic use. Thus, the request for hydrocodone 10/325 acetaminophen #240 is not medically appropriate and necessary.

**Ativan 1mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24. Decision based on Non-MTUS Citation ODG Pain Chapter (updated 12/31/14).

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

**Decision rationale:** Guidelines state that Ativan is not recommended for long term use because efficacy is unproven and there is risk for dependence. Most guidelines limit use to 4 weeks and

recommend other agents such as antidepressants for treatment of anxiety disorder. In this case, there is no diagnosis listed for which this medication is indicated. The medication should not be abruptly discontinued however. The current request for Ativan, 1 mg #120 is not medically appropriate and necessary.