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| Case Number: | CM15-0041300 | | |
| Date Assigned: | 03/11/2015 | Date of Injury: | 11/27/1996 |
| Decision Date: | 04/17/2015 | UR Denial Date: | 02/19/2015 |
| Priority: | Standard | Application Received: | 03/04/2015 |

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: Internal Medicine, Pulmonary Disease

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 62-year-old male, who sustained an industrial injury on 11/27/1996. The diagnoses have included chronic low back pain, failed lumbar back surgery, lumbar pain with radiculopathy and bilateral shoulder impingement syndrome. Treatment to date has included medication. According to the progress report dated 2/4/2015, the injured worker complained of pain in the bilateral arms, bilateral legs, neck, bilateral shoulders, bilateral buttocks, bilateral knees and low back. The injured worker rated the average pain level as 8/10. Review of systems revealed that the injured worker complained of itching, rash and hair loss, memory loss, anxiety and depression. Physical exam revealed a kyphotic posture and slow antalgic gait. The treatment plan was to refill medications. The injured worker was encouraged to continue activities as tolerated.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien CR 12.5mg #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.

MAXIMUS guideline: Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Zolpidem (Ambien).

Decision rationale: The patient is a 62-year-old male with an injury on 11/27/1996. He had chronic low back pain and bilateral shoulder impingement. ODG note that Ambien is for short-term use of 7 to 10 days and is associated with potential mental and physical adverse effects. Also, there is recent documentation of the build up of blood levels of patients taking Ambien and lower doses have been recommended. This patient has been prescribed Ambien 10 mg and Ambien 12.5 CR. Neither is medically necessary for more than 7 to 10 days.

Diphenhydramine Hydrochloride 50mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Diphenhydramine.

Decision rationale: The patient is a 62-year-old male with an injury on 11/27/1996. He had chronic low back pain and bilateral shoulder impingement. ODG noted that diphenhydramine and other sedating antihistamines are not medically necessary. This patient was also prescribed Ambien and Ambien CR. All of three of these medications are for short term use, have similar effects and may decrease physical and mental abilities - especially if used together in the same patient.

Terazosin Hydrochloride 50mg #60: Upheld

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

MAXIMUS guideline: Decision based on Non-MTUS Citation Terazosin FDA approved package insert indications.

Decision rationale: The patient is a 62-year-old male with an injury on 11/27/1996. He had chronic low back pain and bilateral shoulder impingement. Terazosin is FDA approved for the treatment of benign prostatic hypertrophy and hypertension. These conditions are not related to an injury in 1996. There was no documented indication for Terazocin.

Ambien 10mg #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.

MAXIMUS guideline: Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Zolpidem (Ambien).

Decision rationale: The patient is a 62-year-old male with an injury on 11/27/1996. He had chronic low back pain and bilateral shoulder impingement. ODG note that Ambien is for short-term use of 7 to 10 days and is associated with potential mental and physical adverse effects. Also, there is recent documentation of the buildup of blood levels of patients taking Ambien and lower doses have been recommended. This patient has been prescribed Ambien 10 mg and Ambien 12.5 CR. Neither is medically necessary for more than 7 to 10 days.