

Case Number:	CM14-0142943		
Date Assigned:	09/10/2014	Date of Injury:	08/04/1989
Decision Date:	10/10/2014	UR Denial Date:	08/07/2014
Priority:	Standard	Application Received:	09/03/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 61-year-old male was reportedly injured on 8/4/1989. The claimant underwent cervical spine surgery in 1989. The most recent progress note, dated 7/28/2014, indicated that there were ongoing complaints of neck, shoulder and low back pains. Physical examination demonstrated positive cervical facet stress, limited cervical range of motion, and negative Spurling's test. Motor was 5/5 on the left and 5/5 on the right. There was decreased sensation in left C8 distribution, decreased lumbar range of motion due to pain, tenderness to palpation, sensory deficits in the bilateral L5-S1 dermatomes, and positive straight leg raise bilaterally. The patient ambulated slowly with use of the device with severe decreased left shoulder range of motion, especially with abduction. No recent diagnostic imaging studies available for review. Previous treatment included epidural steroid injections, physical therapy, and medications to include lorazepam, Voltaren Gel, Soma, Norco and fentanyl Patches. A request had been made for Ativan 2 mg #30 with 2 refills, which was partially certified for #10, with no refills in the utilization review on 8/6/2014, this request is not considered medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ativan 2mg #10 between 7/28/14 and 11/3/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24 of 127.

Decision rationale: The MTUS guidelines do not support benzodiazepines (Ativan) for long-term use because long-term efficacy is unproven and there is a significant risk of psychological and physical dependence and/or addiction. Most guidelines limit its use to 4 weeks. As such, this request is not considered medically necessary.