

<b>Case Number:</b>	CM14-0080094		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	10/26/2010
<b>Decision Date:</b>	09/19/2014	<b>UR Denial Date:</b>	05/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/30/2014

### 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 Occupational Medicine and is licensed to practice in California. 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 patient is a 56-year-old male who was injured on 10/26/2010 when he was doing heavy lifting and strained his lower back. Prior medication history included Tramadol, Norco, and Robaxin. Prior treatment history has included physical therapy which helped temporarily and TENS unit. Progress report dated 04/24/2014 states the patient presented with complaints of low back pain rated as 3/10 with associated throbbing and aching. According to the patient, his pain is constant and is increased with activity. Objective findings on exam revealed a steady gait. Range of motion of the lumbar spine is decreased in all planes. There is tenderness to palpation of the lumbar paraspinous area with decreased range of motion in extension and flexion. Diagnoses are opioid-type dependence, acquired spondylosis, lumbosacral spondylosis, and thoracic sprain/strain. The patient was prescribed Ativan 1 mg #90. Prior Utilization Review dated 05/05/2014 states the request for Ativan 1mg TID #90 has been found to be medically necessary to allow for weaning to discontinue with reduction of 10% per week over a weaning period of 2 to 3 months.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ativan 1mg TID #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepine Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Benzodiazepine.

**Decision rationale:** As per CA MTUS guidelines, Ativan is a benzodiazepine. It is 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. The medical records submitted for review indicates that he has been taking this medication at least since January, 2014. Thus, continued use is not medically necessary and weaning process needs to be initiated. The request for Ativan 1mg TID #90 is not medically necessary.