

Case Number:	CM15-0178557		
Date Assigned:	09/18/2015	Date of Injury:	08/11/2010
Decision Date:	10/22/2015	UR Denial Date:	08/12/2015
Priority:	Standard	Application Received:	09/10/2015

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: Arizona, California

Certification(s)/Specialty: Family Practice

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 31 year old male who sustained an industrial injury on August 11, 2010. An orthopedic evaluation dated July 08, 2014 reported the worker denies taking any medications at this time. He had present subjective complaint of constant low back pain accompanied by stiffness and decreased motion. The pain radiates into right lower extremity below the knee. The diagnostic impression noted the worker with lumbar spine myofascial sprain strain with radiculopathy; spinal stenosis, and herniated nucleus pulposus lumbar. The plan of care is with recommendation for pain management referral; surgical referral; dispensed gabapentin, Norco, Ibuprofen and Omeprazole. Initial pain management evaluation dated August 07, 2015 reported chief subjective complaint of lower back pain radiating to bilateral lower extremities. The plan of care noted proceeding with surgery, lumbar; possible epidural injection if surgery prolongs; prescribed: Movantik, Percocet. He is also to consult with psychiatrist. A progress note dated July 21, 2015 reported ibuprofen and Gabapentin current medications. A primary treating medication note dated August 06, 2015 with a stamped date mark reported Ativan one twice daily as needed for anxiety and Ambien 10mg every night for insomnia.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ativan 1 mg (unspecified frequency and duration) QTY 60 refills 0 for symptoms related to given diagnosis of depressive disorder as outpatient: Overturned

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

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

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, Benzodiazepines are not recommended for long-term use because its efficacy is unproven and there is a risk of addiction. Most guidelines limit its use to 4 weeks and its range of action includes: sedation, anxiolytic, and anticonvulsant and muscle relaxant. In this case, the claimant does have anxiety. The psychiatrist recommended Ativan for 1 month (1mg BID). The request for the time length and amount is within the guidelines and medically necessary.

Ambien 10 mg (unspecified frequency and duration) QTY 30 refills 0 for symptoms related to given diagnosis of depressive disorder as outpatient: Upheld

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

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 and pg 64.

Decision rationale: The MTUS guidelines do not comment on insomnia. According to the ODG guidelines, recommend that treatment be based on the etiology, with the medications. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. Zolpidem is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). In this case, the claimant was provided it for insomnia due to pain rather than a primary sleep disorder. Quantity and length of use was not specified. The use of Zolpidem (Ambien) as prescribed is not medically necessary.