

Case Number:	CM15-0099024		
Date Assigned:	06/01/2015	Date of Injury:	01/13/2011
Decision Date:	07/09/2015	UR Denial Date:	05/05/2015
Priority:	Standard	Application Received:	05/22/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 54-year-old male, who sustained an industrial injury on 01/13/2011. He has reported subsequent anxiety and depression and was diagnosed with depressive disorder and insomnia. Treatment to date has included anti-anxiety, anti-depressant and sleep medication. In a progress note dated 04/07/2015, the injured worker reported increased memory and concentration, appetite, energy level and sociability and reduced insomnia. Objective findings were notable for a less tense and dysphoric mood and less anxious and dysphoric thought content. A request for authorization of Fioricet, Citalopram, Ambien and Ativan refills was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fioricet #60 x 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate containing analgesics BCA's Page(s): 23.

Decision rationale: The patient was injured on 01/13/11 and presents with anxiety, depression, insomnia, and problems with memory/concentration. The request is for FIORICET #60 X 2 REFILLS. The RFA is dated 04/21/15 and the patient's work status is not provided. The patient has been taking Fioricet as early as 12/05/14. MTUS Guidelines, page 23, in regards to Barbiturate containing analgesics BCA's- such as Fiorinal - states: "Not recommended for chronic pain. The potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents. There is a risk of medication overuse as well as rebound headache." The patient is diagnosed with depressive disorder and insomnia. The reason for the request is not provided. MTUS does not support Barbiturate-containing analgesic agents for chronic pain due to high abuse-risk potential, dependence risk, and a risk of rebound headaches following administration. Therefore, the requested Fioricet IS NOT medically necessary.

Citalopram 10mg #90: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Mental Illness and Stress chapter, Antidepressants for Treatment of MDD.

Decision rationale: The patient was injured on 01/13/11 and presents with anxiety, depression, insomnia, and problems with memory/concentration. The request is for CITALOPRAM 10 MG #90. The RFA is dated 04/21/15 and the patient's work status is not provided. The patient has been taking Citalopram as early as 12/05/14. MTUS Guidelines are silent on Celexa specifically. ODG Guidelines for Antidepressants for Treatment of MDD, chapter Mental Illness and Stress, state, "Many treatment plans start with a category of medication called selective serotonin reuptake inhibitors (SSRIs), because of demonstrated effectiveness and less severe side effects." The patient is diagnosed with depressive disorder and insomnia. The reason for the request is not provided. The patient has been taking this medication as early as 12/05/14; however, there is no documentation of efficacy. ODG guidelines support the use of this medication only with "demonstrated effectiveness." MTUS page 60 also requires documentation of improvement in pain and function when medications are used for chronic conditions. Therefore, the request IS NOT medically necessary.

Ambien 10mg #60 x 2 refills: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines mental illness and stress chapter, zolpidem (Ambien).

Decision rationale: The patient was injured on 01/13/11 and presents with anxiety, depression, insomnia, and problems with memory/concentration. The request is for AMBIEN 10 MG #60 X 2 REFILLS for insomnia. The RFA is dated 04/21/15 and the patient's work status is not provided. The patient has been taking Ambien as early as 12/05/14. MTUS and ACOEM Guidelines are silent with regard to his request. However, ODG Guidelines, mental illness and stress chapter, zolpidem (Ambien) states, "Zolpidem (Ambien, generic available, Ambien CR) is indicated for short term use of insomnia with difficulty of sleep onset (7-10 days). Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Long-term studies have found Ambien CR to be effective for up to 24 weeks in adults." The patient is diagnosed with depressive disorder and insomnia. ODG Guidelines support the use of Ambien for 7 to 10 days for insomnia. However, the patient has been taking this medication since 12/05/14, which exceeds the 7 to 10 day limit indicated by ODG Guidelines. In this case, this medication has been used on a long-term basis, which is not recommended by ODG Guidelines. Therefore, the requested Ambien IS NOT medically necessary.

Ativan 2mg #60 x 2 refills: Upheld

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

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

Decision rationale: The patient was injured on 01/13/11 and presents with anxiety, depression, insomnia, and problems with memory/concentration. The request is for ATIVAN 2 MG #60 WITH 2 REFILLS for anxiety. The RFA is dated 04/21/15 and the patient's work status is not provided. The patient has been taking Ativan as early as 12/05/14. MTUS Guidelines page 24 states, "Benzodiazepines are 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 patient is diagnosed with depressive disorder and insomnia. The patient has been taking Ativan since 12/05/14, and it would appear that this medication is prescribed on a long-term basis. The treating physician does not mention that this is for a short-term use. Benzodiazepines run the risk of dependence and difficulty of weaning per MTUS Guidelines. It is not recommended for long-term use; therefore, the requested Ativan IS NOT medically necessary.