
Independent Medical Review Final Determination Letter

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Dated: 12/23/2013

IMR Case Number:	CM13-0005199	Date of Injury:	07/13/1999
Claims Number:	██████████	UR Denial Date:	07/16/2013
Priority:	Standard	Application Received:	07/30/2013
Employee Name:	████████████████████		
Provider Name:	████████████████████, MD		
Treatment(s) in Dispute Listed on IMR Application:	Amitriptyline HCL 25mg, QHS, #60, with 1 refill and Ambien CR 12.5mg, #30		

DEAR ██████████,

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: PARTIAL OVERTURN. This means we decided that some (but not all) of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, ██████████

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Medicine, has a subspecialty in 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 physician 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.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This IW is a 62 year old woman who injured her back on 7/13/99. She underwent multiple lumbar spine operations which include an L3- S1 spinal fusion and L3-S1 arthrodesis. She has been treated for chronic pain, chronic insomnia, low back pain with radiculopathy, depression, and opioid dependence.

IMR DECISION(S) AND RATIONALE(S)

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

1. Amitriptyline HCL 25mg, QHS, #60 with 1 refill is medically necessary and appropriate.

The Claims Administrator based its decision on the MTUS 2009, Chronic Pain Medical Treatment Guidelines, Antidepressants for chronic pain, pg. 13, which is part the MTUS and Official Disability Guidelines (ODG), which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Low Back Pain, pg. 14, which is part of the MTUS

The Physician Reviewer's decision rationale:

This IW has chronic lumbar pain with radiculopathy despite surgical interventions. She has symptoms of depression and insomnia. With careful monitoring for psychiatric and cardiac rhythm side effects, doses as low as 10 to 25 mg taken at night may offer some real degree of pain relief and return of restorative sleep. Advancing age and polypharmacy add additional elements of risk to this IW. Amitriptyline is medically indicated at this time, as long as a clinical benefit is seen and documented. Diligent monitoring for side effects and/or drug to drug interactions is mandatory for its continued use.

2. Ambien CR 12.5mg, #30 is not medically necessary and appropriate.

The Claims Administrator based its decision on the MTUS 2009, Chronic Pain Medical Treatment Guidelines, Opioids, On-going Management, pg. 78 and Official Disability Guidelines (ODG), which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG)

The Physician Reviewer's decision rationale:

Chronic insomnia remains a difficult problem to treat. Experts recommend treating underlying causes of insomnia first. Sleep hygiene, sleep apnea, sleep latency, and other factors need to be addressed. Studies addressing the long-term use of hypnotics do not demonstrate effectiveness or safety for the different classes of medications used for this purpose. The nonbenzodiazepine hypnotics have been studied extensively. They are indicated for the short term treatment of insomnia. Long-term use of these agents is not recommended. Continued Ambien Cr use is not medically indicated.

ODG Pain treatment

Zolpidem is a prescription short-acting non benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia....They can be habit forming and they may impair function and memory more than opioid pain relievers....Zolpidem is linked to a sharp increase in ED visits, so it should be used safely for only a short period of time.

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.

[REDACTED]

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