

Case Number:	CM13-0005517		
Date Assigned:	04/25/2014	Date of Injury:	03/12/1997
Decision Date:	06/10/2014	UR Denial Date:	07/11/2013
Priority:	Standard	Application Received:	08/01/2013

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 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 injured worker is a 51-year-old male who reported an injury on 03/12/1997. The mechanism of injury was not stated. Current diagnoses include lumbar disc degeneration and myofascial pain syndrome. The injured worker was evaluated on 01/23/2014. The injured worker reported 8/10 low back pain with radiation to the bilateral lower extremities. Physical examination on that date revealed no acute distress. Current medications include Ambien 10 mg and Provigil 200 mg. Treatment recommendations at that time included continuation of current medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

ZOLPIDEM TARTRATE 10MG #30 WITH 1 REFILL: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Insomnia Treatment Section.

Decision rationale: The Official Disability Guidelines (ODG) state insomnia treatment is recommended based on etiology. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. The injured worker does not maintain a diagnosis

of chronic insomnia. There is no evidence of sleep disturbance. There is also no frequency listed in the current request. Based on the clinical information received, the request is not medically necessary or appropriate.

MODAFINIL 200MG #21 WITH 1 REFILL: 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), Chronic Pain Chapter, Modafinil (Provigil®) Section.

Decision rationale: The Official Disability Guidelines (ODG) state Modafinil is not recommended solely to counteract sedation effects of narcotics until after first considering reducing excessive narcotic prescribing. Modafinil is indicated to improve wakefulness in adult injured workers with excessive sleepiness associated with narcolepsy, obstructive sleep apnea and shift work sleep disorder. The injured worker does not maintain any of the above mentioned diagnoses. There is no documentation of an attempt at reducing excessive narcotic prescribing prior to the initiation of modafinil. There is also no frequency listed in the current request. Based on the clinical information received and the Official Disability Guidelines, the request is not medically necessary or appropriate.