

Case Number:	CM13-0011369		
Date Assigned:	12/27/2013	Date of Injury:	08/16/2000
Decision Date:	10/31/2014	UR Denial Date:	07/31/2013
Priority:	Standard	Application Received:	07/31/2013

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 Emergency 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 had a reported date of injury on 8/16/2000. Mechanism of the injury was, "jumped 6-8feet". The patient has a diagnosis of lumbar disc degeneration, adjustment disorder and chronic low back pain. Patient with post lumbar fusion(3/2004).Medical reports were reviewed and valid progress reports were available and reviewed until 7/1/13. The notes up to 10/14/14 were sent. These recent notes were not reviewed except for historical information since prospective information does not retrospectively change the criteria used for IMR in the original medication request as per MTUS guidelines.The patient complained of back pain, spasms and weakness, the pain was 9-10/10. And there were complaints of sleep problems due to pain. The objective exam revealed normal ambulation, decreased range of motion of lumbar spine. There were tenderness and muscle spasms noted and a dose of Toradol was given in the office. There were no imaging or electrodiagnostic reports were provided for review. At time of request medications included Hydrocodone, Ambien and Topical Cream. The Independent Medical Review is for Ambien 10mg #30. The prior Utilization Review (UR) on 7/31/13 recommended denial.

IMR ISSUES, DECISIONS AND RATIONALES

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

AMBIEN 10MG #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG- Zolpidem

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

Decision rationale: There are no specific sections in the MTUS chronic pain or ACOEM guidelines that relate to this topic. Ambien is a Benzodiazepine agonist approved for insomnia. As per ODG guidelines, it recommends treatment of underlying cause of sleep disturbance and recommend short course of treatment. Patient has been on Ambien chronically for at least a year. There is no documentation of other conservative attempts at treatment of sleep disturbance or sleep studies. Patient's sleep problem is noted to be due to pain which should be the primary target for treatment to improve patient's sleep. The number of tablets of 30 is not appropriate for short term use or weaning as per ODG Guidelines. The chronic use of Ambien is not medically appropriate and is not medically necessary.