

Case Number:	CM13-0021099		
Date Assigned:	10/11/2013	Date of Injury:	09/27/2003
Decision Date:	08/13/2014	UR Denial Date:	08/28/2013
Priority:	Standard	Application Received:	09/06/2013

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 Internal Medicine has a subspecialty in Pulmonary Disease 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 43-year-old male who reported an injury on 09/27/2003 secondary to an unspecified mechanism of injury. The injured worker was evaluated on 08/08/2013 for reports of cervical and lumbar spine and left knee pain. The exam noted the knee flexion to be limited to 140 degrees bilaterally with tenderness over the medial joint line and a positive patellofemoral grind test. The muscle strength was noted to be at 4/5 in the quadriceps and hamstrings bilaterally. The exam also noted the patient described gastric symptoms and had a history of nonsteroidal anti-inflammatory drug (NSAID) usage and reported sleep difficulty. The diagnoses included chronic cervical musculoligamentous sprain/strain with disc herniation, status post anterior cervical fusion and decompression, lumbar disc herniation, left shoulder posterior labral tear, and subacromial impingement and rotator cuff tendonitis, right shoulder subacromial impingement was status post arthroscopy, left knee medial meniscal tear and arthroscopy with residual chondromalacia of the patella and right knee chondromalacia of the patella. The treatment plan included continued medication therapy and a possible Synvisc injection. The Request for Authorization dated 08/08/2013 was found in the documentation provided. The rationale for the request was found in the chart note and indicated the Prilosec was used for gastric symptoms and Ambien was used for sleep difficulty.

IMR ISSUES, DECISIONS AND RATIONALES

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

PRILOSEC 20MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68.

Decision rationale: The MTUS Guidelines may recommend the use of proton pump inhibitors when the patient is at intermediate risk for gastrointestinal events and on NSAIDs. The injured worker is on NSAIDs and indicated gastric symptoms; however, the specific gastric symptoms were not described in the documentation provided. Furthermore, the request does not include the specific dosage and frequency being prescribed. Therefore, due to the significant lack of specific clinical findings of gastric symptoms and the specific frequency and dosage being prescribed, not included in the prescription, the request is not medically necessary.

AMBIEN 5MG #60: 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) Pain, Zolpidem (Ambien).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Zolpidem (Ambien®).

Decision rationale: The Official Disability Guidelines may recommend Ambien for short term use for the treatment of insomnia. The patient does report sleep difficulties; however the clinical notes indicate the request is for a refill of Ambien. The refill of this prescription would exceed the time frame to be considered short term use. Therefore, due to the time the medication has been prescribed, exceeding the time frame to be considered short term, the request is not medically necessary.