

<b>Case Number:</b>	CM13-0046116		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	09/06/2011
<b>Decision Date:</b>	02/28/2014	<b>UR Denial Date:</b>	10/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2013

### 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 Internal Medicine, has a subspecialty in Pulmonary 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 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. 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 is a 50-year-old female who reported an injury on 09/06/2011. The patient was seen by [REDACTED] on 09/09/2013. The patient reported ongoing headaches, neck pain and stiffness, left upper extremity pain, right wrist pain, low back pain with stiffness, depression with anxiety, and sleep difficulty. Physical examination revealed limited cervical range of motion, tenderness to palpation of the left elbow, tenderness and pain in bilateral hands and wrists, weak grip strength on the left, limited lumbar range of motion, muscle spasm with tenderness to palpation, and normal range of motion of bilateral lower extremities. The patient is diagnosed with cephalgia, status post extensive cervical spine fusion, status post left elbow surgery, tendonitis in bilateral wrists, lumbar spine sprain and strain, myofasciitis, history of radiculopathy, depression with anxiety, and sleep difficulty. Treatment recommendations included symptomatic medications to help the patient sleep.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Symptomatic Medications:** 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, Insomnia Treatment.

**Decision rationale:** Official Disability Guidelines state insomnia treatment is recommended based on etiology. Empirically supported treatment includes stimulus control, progressive muscle relaxation, and paradoxical intention. As per the documentation submitted, the patient does report sleep difficulty. However, there is no evidence of a failure to respond to non-pharmacological treatment prior to the request for a prescription product. Additionally, the name of the particular medication with dosage, frequency, and quantity were not specified in the request. Therefore, the request cannot be determined as medically appropriate. As such, the request is non-certified.