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| Case Number: | CM13-0055877 | | |
| Date Assigned: | 12/30/2013 | Date of Injury: | 11/28/2007 |
| Decision Date: | 05/15/2014 | UR Denial Date: | 11/08/2013 |
| Priority: | Standard | Application Received: | 11/21/2013 |

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 has a subspecialty in Pain Management and is licensed to practice in Texas and Oklahoma. 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 50-year-old female who reported an injury on 11/28/2007. The mechanism of injury was not provided. Current diagnoses include status post posterior lumbar interbody fusion, right lower extremity radiculopathy, morbid obesity, and medication induced gastritis. The injured worker was evaluated on 12/04/2013. Physical examination revealed significant tenderness to palpation, limited range of motion, decreased motor strength, positive straight leg raising and decreased sensation on the right. Treatment recommendations included continuation of current medication including Prilosec 20 mg and Ambien 10 mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

ZOLPIDEM 10MG #30: Upheld

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

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. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset for 7 days to 10 days. As per the documentation submitted, there is no indication of chronic insomnia or sleep disturbance. There is also no evidence of a failure to respond to nonpharmacologic treatment prior to the initiation of a prescription product. Additionally, there is no frequency listed in the current request. Therefore, the request is non-certified.