

Case Number:	CM13-0067376		
Date Assigned:	01/03/2014	Date of Injury:	09/18/2006
Decision Date:	05/19/2014	UR Denial Date:	12/04/2013
Priority:	Standard	Application Received:	12/17/2013

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 & Rehabilitation and is licensed to practice in Illinois. 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 56-year-old female who reported an injury on 09/18/2006. The mechanism of injury was not provided for review. The injured worker's treatment history included multiple surgical interventions to the right shoulder, postoperative physical therapy, and a home exercise program. The injured worker was evaluated on 10/16/2013. It was documented the injured worker had continued complaints of neck pain. Objective findings included tenderness to palpation of the cervical paraspinal musculature with restricted range of motion secondary to pain and 5-/5 motor strength in the bilateral shoulders. The injured worker's diagnoses included persistent neck pain and status post surgical intervention of the right shoulder. The injured worker's treatment plan included physical therapy for the neck, Tylenol extra strength as needed for pain control, Ambien 10 mg every night as needed for sleep, and follow-up visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

AMBIEN 10MG QHS PRN FOR SLEEP #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 ODG (Pain Chapter).

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

Decision rationale: The Expert Reviewer's decision rationale: The requested Ambien 10 mg every night as needed for sleep #30, with 1 refill, is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not address this medication. Official Disability Guidelines recommend this medication for very short durations of treatment not to exceed 1 month, after the injured worker had failed to respond to nonpharmacological treatments for insomnia related to chronic pain. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's sleep hygiene to support the need for pharmacological interventions. There is no documentation that the injured worker has failed to respond to nonpharmacological interventions to assist with sleep pattern deficits. Additionally, as the request includes 1 refill, the request itself exceeds the treatment duration recommended by the Official Disability Guidelines. As such, the requested Ambien 10 mg every night as needed for sleep #30 with 1 refill is not medically necessary or appropriate.