

Case Number:	CM13-0068046		
Date Assigned:	01/08/2014	Date of Injury:	06/30/2009
Decision Date:	04/24/2014	UR Denial Date:	11/27/2013
Priority:	Standard	Application Received:	12/19/2013

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 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 is a 53-year-old male who reported an injury on 06/30/2009. The mechanism of injury was not provided. The patient is currently diagnosed as status post left total hip replacement and status post right total hip replacement. The patient was seen by [REDACTED] on 11/14/2013. The patient reported 7/10 bilateral hip pain. It was noted that the patient has been previously treated with chiropractic therapy in the past. Physical examination on that date revealed an antalgic gait. Range of motion examination was deferred at that time. Treatment recommendations included a renewal of OxyContin 10 mg and Ambien 10 mg. Six sessions of chiropractic therapy for bilateral hip pain was also recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic therapy for bilateral hips QTY: 6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

Decision rationale: California MTUS Guidelines state manual therapy and manipulations is recommended for chronic pain if caused by musculoskeletal conditions. As per the

documentation submitted, the patient has reported improvement in symptoms with previous chiropractic therapy. However, there is no documentation of objective functional improvement following an initial course of chiropractic treatment. Therefore, ongoing treatment cannot be determined as medically appropriate. There was also no comprehensive physical examination provided on the requesting date of 11/14/2013. Based on the clinical information received, the request is non-certified.

Ambien 10mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Procedure Summary.

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 to 10 days. As per the documentation submitted, the patient was issued a renewal prescription of Ambien 10 mg on 11/14/2013. However, there is no documentation of chronic insomnia or sleep disturbance. There was also no evidence of a failure to respond to nonpharmacologic treatment. As guidelines do not recommend long-term use of this medication, the current request cannot be determined as medically appropriate. Therefore, the request is non-certified.