

Case Number:	CM13-0069791		
Date Assigned:	01/03/2014	Date of Injury:	08/20/1998
Decision Date:	05/02/2014	UR Denial Date:	12/05/2013
Priority:	Standard	Application Received:	12/23/2013

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 Sports Medicine and is licensed to practice in Texas. 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 58-year-old female who reported an injury on 08/20/1998. The mechanism of injury was not provided. The orthopedic re-evaluation dated 11/26/2013 indicated the injured worker had complaints of left shoulder pain with inability to perform any overhead reaching. Upon examination of the left shoulder there was tenderness over the supraspinatus region, specifically over the greater tuberosity. There is also tenderness over the subacromial region and acromioclavicular joint. Range of motion of the left shoulder was flexion at 160 degrees and abduction at 180 degrees. Hawkins sign, impingement sign/Neer, and thumbs down test were all positive. Medications included Pantoprazole sodium 20 mg daily, Ambien 10 mg daily, and Fioricet.

IMR ISSUES, DECISIONS AND RATIONALES

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

AMBIEN 10MG, 1 TAB PO QT #30: 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) pain, Zolpidem (Ambien®).

Decision rationale: The California MTUS/ACOEM does not address Ambien. However, the Official Disability Guidelines state that Ambien is a prescription short-acting non-benzodiazepine hypnotic which is approved for short-term (usually 2 to 6 weeks) treatment of insomnia. The records submitted for review failed to include documentation of the duration the injured worker had been utilizing Ambien. The records submitted for review failed to include documentation of the injured worker's response to Ambien. The request as submitted failed to include the frequency as submitted. The request for Ambien 10 mg 1 tab PO QT # 30 is not medically necessary and appropriate.

FIORICET 1 TAB PO ½ HOUR BEFORE HEADACHE #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/pro/fiorcet.html>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents (BCAs) Page(s): 23.

Decision rationale: The California MTUS states that barbiturate-containing analgesic agents (BCAs) are not recommended for chronic pain. The potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to barbiturate constituents. There is also a risk of medication overuse as well as rebound headache. The records submitted for review failed to include documentation of the duration the injured worker had been utilizing Fioricet. The records submitted for review failed to include documentation of the injured worker's response to Fioricet. The request as submitted failed to include a dose and frequency. The request for Fioricet 1 tab PO ½ hour before headache # 60 is not medically necessary and appropriate.