

Case Number:	CM14-0007542		
Date Assigned:	04/02/2014	Date of Injury:	09/19/2011
Decision Date:	05/26/2014	UR Denial Date:	12/10/2013
Priority:	Standard	Application Received:	12/18/2013

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 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 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 48-year-old male who reported an injury on 09/11/2011 after running with a blower backpack which reportedly caused a sudden onset of pain in the mid back. The injured worker's treatment history included physical therapy, injections, medications, and activity restrictions. The injured worker was evaluated on 11/07/2013. It was documented that the injured worker had a flare up of symptoms that caused pain rated 9/10. Physical findings included reduced range of motion of the cervical spine. The injured worker's diagnoses included thoracic pain, cervical strain, osteoarthritis of the spine, degenerative disc disease of the thoracic spine, facet syndrome, cervical radiculopathy, thoracic radiculopathy, chronic pain, and low back pain. A request was made to initiate Ambien to assist with insomnia related to pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

AMBIEN 5MG #30 (TAKE 1 AT NIGHT AS NEEDED): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC 2013 Pain, Insomnia Treatment.

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 requested Ambien 5 mg take 1 at night as needed is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not specifically address insomnia treatments. Official Disability Guidelines recommend insomnia treatments for injured workers who have persistent sleep disturbances related to chronic pain that have been recalcitrant to nonpharmacological measures. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's sleep hygiene to support that they have continued insomnia related complaints. Additionally, there is no documentation that the injured worker has failed to respond to nonpharmacological interventions as the injured worker had previously been on Trazodone to treat pain related insomnia. As such, the requested Ambien 5 mg #30 take 1 at night as needed is no medically necessary or appropriate.