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| Case Number: | CM14-0112465 | | |
| Date Assigned: | 08/01/2014 | Date of Injury: | 03/17/2001 |
| Decision Date: | 10/23/2014 | UR Denial Date: | 07/09/2014 |
| Priority: | Standard | Application Received: | 07/18/2014 |

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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:

This is a 53-year-old female with a 3/17/01 date of injury. A specific mechanism of injury was not described. According to a progress report dated 6/24/14, the patient complained of increasing right sided low back pain that radiated to the calf/ankle, rated 5/10. Her sleep is reasonable, pain is "so aggravating". She was bedridden for two days recently due to intensity of complaints. Objective findings: mild right lumbar paraspinal muscle tenderness, limited and painful lumbar range of motion, moderately diminished sensation to pinprick testing at L5 and S1 dermatomes. Diagnostic impression: failed back syndrome, thoracic or lumbosacral neuritis or radiculitis, status post trial of spinal cord stimulator, coccydynia, associated mood disorder, sleep disorder. Treatment to date: medication management, activity modification, surgery, spinal cord stimulator. A UR decision dated 7/9/14 modified the request for Ambien 10mg #30 to allow this one fill for weaning purposes. There is a lack of high quality evidence based medicine in support of sedating agents when patients are on high dose opioids.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10 mg tablet #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline (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, Ambien

Decision rationale: CA MTUS does not address this issue. ODG and the FDA state that Ambien is approved for the short-term (usually two to six weeks) treatment of insomnia. Additionally, pain specialists rarely, if ever, recommend Ambien for long-term use. However, this patient has been on Ambien since at least 5/21/14, if not earlier. The 5/21/14 report is the earliest report submitted for review. In addition, there is no documentation that the provider has addressed non-pharmacologic methods for sleep disturbances, such as proper sleep hygiene. Therefore, the request for Ambien 10mg tablet #30 is not medically necessary.