

<b>Case Number:</b>	CM14-0128112		
<b>Date Assigned:</b>	08/15/2014	<b>Date of Injury:</b>	04/09/2013
<b>Decision Date:</b>	12/16/2014	<b>UR Denial Date:</b>	07/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/11/2014

### 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 Occupational Medicine 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:

According to the records made available for review, this is a 50-year-old female with a 4/9/13 date of injury. At the time (7/15/14) of the Decision for Ambien 10mg #30, Lovenox injections 40mg, and Ice machine rental, there is documentation of subjective (right hip pain) and objective (painful right hip range of motion and positive anterior labral test) findings, current diagnoses (right hip osteoarthritis and lumbosacral degenerative disc disease), and treatment to date (activity modification and medications (including ongoing treatment with Ambien since at least 2013)). Medical report identifies an associated request for right total hip arthroplasty that has been authorized/certified and that patient wakes up at night due to pain. Regarding Ambien 10mg #30, there is no documentation of insomnia; an intention for short-term (usually two to six weeks) treatment; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Ambien use to date.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien 10mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Treatment of Insomnia- Ambien (Zolpidem)

**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, Zolpidem

**Decision rationale:** MTUS does not address this issue. ODG identifies Ambien (zolpidem) as a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of right hip osteoarthritis and lumbosacral degenerative disc disease. However, despite documentation that patient wakes up at night due to pain, there is no (clear) documentation of insomnia. In addition, given documentation of records reflecting prescription for Ambien since at least 2013, there is no documentation of short-term (usually two to six weeks) treatment. Furthermore, given documentation of ongoing treatment with Ambien, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Ambien use to date. Therefore, based on guidelines and a review of the evidence, the request for Ambien 10mg, #30 is not medically necessary.

**Lovenox injections 40mg:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mosby's Drug Consult

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://www.drugs.com/pro/lovenox.html#indications>

**Decision rationale:** MTUS and ODG do not address this issue. Medical Treatment Guideline identifies documentation of a condition/diagnosis with supportive subjective/objective findings for which Lovenox is indicated (such as patients undergoing abdominal surgery who are at risk for thromboembolic complications, patients undergoing hip replacement surgery, during and following hospitalization, patients undergoing knee replacement surgery, and/or patients who are at risk for thromboembolic complications due to severely restricted mobility during acute illness), as criteria necessary to support the medical necessity of Lovenox. Within the medical information available for review, there is documentation of diagnoses of right hip osteoarthritis and lumbosacral degenerative disc disease. In addition, there is documentation of an associated request for right total hip arthroplasty that has been authorized/certified. However, given documentation of a request for Lovenox injections 40mg, there is no documentation of the quantity requested. Therefore, based on guidelines and a review of the evidence, the request for Lovenox injections 40mg is not medically necessary.

**Ice machine rental:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Continuous - flow cryotherapy

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis, Continuous-flow cryotherapy

**Decision rationale:** MTUS does not address this issue. ODG states that continuous-flow cryotherapy is recommended postoperatively for up to 7 days, including home use. Within the medical information available for review, there is documentation of diagnoses of right hip osteoarthritis and lumbosacral degenerative disc disease. In addition, there is documentation of an associated request for right total hip arthroplasty that has been authorized/certified. However, there is no documentation of the number of days requested. Therefore, based on guidelines and a review of the evidence, the request for Ice machine rental is not medically necessary.