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| Case Number: | CM14-0139474 | | |
| Date Assigned: | 09/05/2014 | Date of Injury: | 04/27/1997 |
| Decision Date: | 10/10/2014 | UR Denial Date: | 08/16/2014 |
| Priority: | Standard | Application Received: | 08/28/2014 |

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 Physical Medicine & 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 75-year-old male who reported an injury on 04/27/1997 due to an unknown mechanism of injury. The injured worker reportedly sustained an injury to his right hip. The injured worker ultimately underwent sacroiliac joint fusion. The injured worker's treatment history included surgical intervention, medications, physical therapy, and a home exercise program. The injured worker was evaluated on 08/08/2014. It was documented that the patient had normal lumbar range of motion with significant weakness of the right quadriceps, tibialis anterior, extensor hallucis longus, and post tibialas and gastroc reflexes rated at a 4/5. The injured worker's diagnoses included thoracic/lumbosacral neuritis, sacral disorders, spinal stenosis, degeneration of the lumbar spine, and postlaminectomy syndrome. The injured worker's medications included Soma 500 mg, Ambien 5 mg, ibuprofen 600 mg, and Percocet 10/325 mg. A request was made for a refill of medications. However, no justification for the request was provided. No Request for Authorization form was submitted to support the request for Ambien.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 5mg #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, Zolpidem.

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: California Medical Treatment Utilization Schedule does not address this medication. Official Disability Guidelines recommend this medication for patients who have insomnia related to chronic pain for short durations of treatment. The clinical documentation submitted for review does not indicate that the injured worker has been on this medication for an extended duration time. However, the injured worker's most recent clinical evaluation dated 08/08/2014 did not provide an adequate assessment of the patient's sleep hygiene to support deficits that would require pharmacological management. Additionally, there is no documentation that the patient has failed to respond to nonpharmacological interventions to assist with re-establishment of sleep patterns disrupted by chronic pain. Therefore, the use of this medication would not be supported in this clinical situation. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Ambien 5 mg #30 is not medically necessary or appropriate.