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| Case Number: | CM14-0025552 | | |
| Date Assigned: | 06/13/2014 | Date of Injury: | 10/02/1993 |
| Decision Date: | 07/15/2014 | UR Denial Date: | 01/29/2014 |
| Priority: | Standard | Application Received: | 02/28/2014 |

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 and Rehabilitation and is licensed to practice in Nevada. 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 38 year-old female who was reportedly injured on 10/2/1993. The injured worker underwent a lumbar interbody fusion at L4/5 and L5/S1 on 12/10/1998 and removal of hardware on 12/7/1999. The mechanism of injury is not listed. Progress notes from 12/5/2013 to 4/15/2014, indicate that there are ongoing complaints of low back pain. No spine or neurological exam documented. MRI of the lumbar spine dated 2010 showed mild ligamentum flavum hypertrophy at L3/4 and L4/5, interbody fusion and posterior decompression at L4/5 and L5/S1 without central or foraminal narrowing. Previous medications: Morphine ER 60 mg and Oxycodone 30 mg. A request had been made for Ambien 10 mg #30 and was not approved in the utilization review on 1/29/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

AMBIEN 10 MG QTY 30 DAY SUPPLY 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) ODG -TWC / ODG Integrated Treatment/Disability Duration Guidelines; Pain (Chronic) - (updated 6/10/14).

Decision rationale: California Medical Treatment Utilization Schedule Guidelines/A American College of Occupational and Environmental Medicine do not address this request. Official Disability Guidelines list Zolpidem (Ambien) as a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Given the date of injury in clinical presentation, this request is not considered medically necessary.