

Case Number:	CM14-0089811		
Date Assigned:	09/10/2014	Date of Injury:	06/02/2006
Decision Date:	10/14/2014	UR Denial Date:	05/29/2014
Priority:	Standard	Application Received:	06/13/2014

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 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 underlying date of injury in this case is 06/02/2006. The date of the initial utilization review under appeal is 05/29/2014. The primary treating diagnosis is lumbar disc degeneration. On 05/09/2014, the primary treating physician saw the patient in followup. At that time, the patient reported increasing pain in the neck and decreasing pain in the lumbar spine as well as increasing pain in the left hip with sciatic pain and unchanged pain in the right hip. The treating physician opined that the patient was stable and doing well on medications and uses occasional oxycodone for severe pain and needed a refill, and she also needed a refill on her current daily medications. A prescription was provided for Ambien 10 mg #30 as well as Ambien 5 mg #30, oxycodone, Soma, and Ultram.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10mg QTY 30.00: 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) Pain/Insomnia

Decision rationale: This medication is not discussed in the California Medical Treatment Utilization Schedule. Official Disability Guidelines discusses this medication under pain/insomnia treatment. This guideline notes that Ambien is indicated for short- term use up to 10 days and that long-term studies have found this medication to be effective for up to 24 weeks in adults. The guidelines do not support this medication for use for a more prolonged chronic period of time. Moreover, the guidelines recommend pharmacological treatment of insomnia only after specific evaluation of the cause of insomnia and initial trial on nonpharmacological treatment. The guidelines have not been met to support an indication for continued use of this medication. This request is not medically necessary.

Ambien 5mg QTY 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) Pain/Insomnia

Decision rationale: This medication is not discussed in the California Medical Treatment Utilization Schedule. Official Disability Guidelines discusses this medication under pain/insomnia treatment. This guideline notes that Ambien is indicated for short- term use up to 10 days and that long-term studies have found this medication to be effective for up to 24 weeks in adults. The guidelines do not support this medication for use for a more prolonged chronic period of time. Moreover, the guidelines recommend pharmacological treatment of insomnia only after specific evaluation of the cause of insomnia and initial trial on nonpharmacological treatment. The guidelines have not been met to support an indication for continued use of this medication. This request is not medically necessary.

Soma 350mg QTY:60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section on carisoprodol/Soma, Page(s): page(s) 29.

Decision rationale: The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on carisoprodol/Soma, page 29, express concern in particular about the potential for abuse of this medication, particularly in combination with opioid medications. The medical records contain very limited documentation regarding the rationale for this request or its effectiveness or benefit. This request is not medically necessary.