

Case Number:	CM15-0002872		
Date Assigned:	01/13/2015	Date of Injury:	02/12/2003
Decision Date:	03/25/2015	UR Denial Date:	12/05/2014
Priority:	Standard	Application Received:	01/06/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, New York, Florida

Certification(s)/Specialty: Internal Medicine, Pulmonary Disease, Critical Care Medicine

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 49-year-old male who reported an injury on 01/03/2006. A previous request was made on 11/14/2014 for Temazepam, Fluoxetine, and Buspar. The medications were non-certified due to the guidelines not recommending long term use of benzodiazepines and insufficient information regarding medical necessity and no concurrent diagnosis of depression for use of antidepressants for chronic pain management. The injured worker had been provided with psychological evaluation and treatment, as well as medication management for persistent symptoms of depression, anxiety, and stress related medical complaints. It was reported that he had not had any significant side effects or negative interactions with the use of his medications. The treating physician indicated that the medications worked together as an interaction, and that by removing by 1 medication, it could tip the scale to cause worsened symptoms in all areas. There was no comprehensive physical examination provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien CR Tab 12.5 MG #45: 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)

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, Insomnia Treatment.

Decision rationale: The Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset. The injured worker has continuously utilized the above medication. There is no documentation of a failure of nonpharmacologic treatment for insomnia prior to the initiation of a prescription product. There is also no frequency listed in the request. Given the above, the request is not medically appropriate.