

Case Number:	CM15-0008087		
Date Assigned:	01/26/2015	Date of Injury:	09/13/2010
Decision Date:	03/24/2015	UR Denial Date:	12/11/2014
Priority:	Standard	Application Received:	01/14/2015

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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 55-year-old female who reported an injury on 09/13/2010. The mechanism of injury was not stated. The current diagnoses include brachial neuritis or radiculitis, recurrent dislocation of the shoulder, and dislocation of the elbow. The injured worker presented on 12/03/2014, with complaints of no significant improvement since the prior examination. Upon examination of the cervical spine, there was paravertebral muscle tenderness, spasm, restricted range of motion, and reduced sensation in the right ulnar nerve distribution. Examination of the bilateral shoulders revealed anterior tenderness, restricted range of motion, and positive impingement sign on the left. Examination of the right elbow revealed lateral epicondyle tenderness, medial epicondyle tenderness, and restricted flexion and extension, with positive Tinel's sign. There was a well healed scar over the right wrist, with restricted range of motion. Recommendations included continuation of the current medication regimen of omeprazole 20 mg, orphenadrine ER 100 mg, and hydrocodone 5/325 mg. There was no Request for Authorization form submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zolpidem Tartrate 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 Pain (Chronic)

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 recommend insomnia treatment based on etiology. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. There is no documentation of a failure to respond to nonpharmacologic treatment for insomnia prior to the request for a prescription product. There is no indication that this injured worker is currently using Ambien 5 mg. The injured worker does not maintain a diagnosis of insomnia. There is also no frequency listed in the request. Given the above, the request is not medically appropriate.