

Case Number:	CM15-0189714		
Date Assigned:	10/01/2015	Date of Injury:	02/12/2003
Decision Date:	11/09/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application Received:	09/25/2015

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: Connecticut, California, Virginia
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 50 year old female who sustained an industrial injury on 1-12-03. The injured worker is being treated for lumbar disc disease; lumbar facet syndrome. She currently (8-10-15) complains of constant low back pain (the record was handwritten and some parts were illegible). Her sleep quality was not present. Her back pain is increased (4-22-15) with prolonged sitting and standing. On physical exam (6-3-15) there was tenderness to palpation of the lumbar spine (records were hand written and parts were illegible). The 5-8-15 note indicated that on 1-5-15 the injured worker continued to complain of persistent low back pain associated with numbness and tingling to the bilateral lower extremities with a pain level of 7 out of 10 without medication and 3-4 out of 10 with medication. She was on the following medications: Ultram, Ambien, Axid and Fexmid. She does home exercise program. Per the 4-8-15 note she has failed physical therapy, chiropractic therapy, rest, home exercise program and medications. She has been on Ambien since at least 1-5-15. She had an MRI of the lumbar spine showing multilevel degenerative disc disease, facet arthropathy. The request for authorization dated 8-21-15 was for Ambien 10mg #30; replacement of ergonomic chair. On 8-27-15 Utilization Review non-certified the requests for Ambien 10mg #30; ergonomic chair replacement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10mg #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 (ODG), Pain chapter - Zolpidem (Ambien).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) zolpidem, insomnia (mental health).

Decision rationale: According to the ODG guidelines, Ambien is indicated for short-term treatment (two to six weeks) of insomnia and is not considered appropriate in for long-term sleep concerns. There are other medications and non-pharmacologic modalities that should be considered as long-term treatments for insomnia. Per the ODG Guidelines for Insomnia, Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Other modalities for sleep improvement should be considered, along with possible other medications that are more appropriate for long-term treatment. If continued treatment with Ambien is required, more detailed documentation of failed sleep treatments and reasoning as to why other pharmacotherapy is not attempted should be provided, along with sleep study data. Without a more detailed reason for the request, the request cannot be considered medically necessary based on the provided documents

Ergonomic chair replacement: Upheld

Claims Administrator guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg - Durable medical equipment (DME).

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Prevention.

Decision rationale: The MTUS ACOEM guidelines state that the primary prevention of work-related complaints depends on reducing exposure to physical, personal, and psychosocial stressors. For example, engineering controls, including ergonomic workstation evaluation and modification, and job redesign to accommodate a reasonable proportion of the workforce may well be the most cost-effective measures in the long run. In this case, it is possible that the patient's chair is broken based on the provided records, but evidence of the claim should be objectively substantiated in order to facilitate certification. Without clear evidence that the chair does, in fact, need to be replaced, the request cannot be considered medically necessary at this time.