

Case Number:	CM15-0022932		
Date Assigned:	02/12/2015	Date of Injury:	11/09/2010
Decision Date:	04/08/2015	UR Denial Date:	01/27/2015
Priority:	Standard	Application Received:	02/06/2015

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, 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 58-year-old male who reported an injury on 11/09/2010. The mechanism of injury was not stated. The current diagnoses include lumbar or lumbosacral disc degeneration, thoracic or lumbosacral neuritis or radiculitis, disorders of sacrum, and sprain/strain of the lumbar region. The injured worker presented on 01/15/2015 for a follow-up evaluation regarding low back pain. The injured worker reported 8/10 low back pain with radiation into the right lower extremity. The current medication regimen includes Wellbutrin 100 mg, Norco 10/325 mg, naproxen, Protonix 20 mg, Zoloft 100 mg, senna 8.6 mg, and Ambien 5 mg. Upon examination, there was restricted lumbar range of motion with flexion limited to 30 degrees, extension to 10 degrees, muscle tenderness, spinous process tenderness at L4-5, and positive straight leg rising bilaterally. There was 4/5 motor weakness in the bilateral lower extremities with decreased sensation over the right L4-S1 dermatomes. Recommendations at that time included continuation of the current medication regimen. It was also noted that the injured worker was pending authorization for a spinal cord stimulator implantation. A Request for Authorization form was then submitted on 02/04/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zolpidem 5mg, quantity: 30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Work Loss Data Institute, Official Disability Guidelines (ODG), Treatment in Workers Compensation (TWC), 5th Edition, Pain (Chronic) 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) Chronic Pain Chapter, Insomnia Treatment.

Decision rationale: The California MTUS Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. In this case, the injured worker has utilized the above medication since at least 08/2014. There is no documentation of a failure of non pharmacologic treatment prior to the initiation of a prescription product. There is no mention of an improvement in symptoms. Additionally, the request as submitted failed to indicate a frequency. Given the above, the request is not medically appropriate.