

Case Number:	CM15-0211011		
Date Assigned:	10/29/2015	Date of Injury:	10/07/2010
Decision Date:	12/16/2015	UR Denial Date:	10/09/2015
Priority:	Standard	Application Received:	10/26/2015

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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative 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:

This injured worker is a 49 year old female, who sustained an industrial injury on 10-07-2010. The injured worker was diagnosed as having thoracic-lumbosacral neuritis-unspecified, disorder sacrum, spinal stenosis-lumbar with neurogen claud, acquired spondylolisthesis and pain joint in pelvis and thigh. On medical records dated 05-11-2015 and 09-28-2015, there was no of documentation of sleep hygiene and no document of documentation-discussion of insomnia was noted. Treatments to date included medication. Current medications were listed as Gabapentin, Flexeril, Naproxen Sodium, Norco and Ambien (since at least 05-2015). The Utilization Review (UR) was dated 10-09-2015. A Request for Authorization was submitted. The UR submitted for this medical review indicated that the request for Ambien 5 mg Qty 30, 1 tab by mouth every night as needed was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 5 mg Qty 30, 1 tab by mouth every night as needed: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Goodman's & Gilman's The Pharmacological Basis of Therapeutics; Physician's Desk Reference.

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, Sleep Medication.

Decision rationale: Regarding the request for Ambien, California MTUS guidelines are silent regarding the use of sedative hypnotic agents. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there are no subjective complaints of insomnia, no discussion regarding how frequently the insomnia complaints occur or how long they have been occurring, no statement indicating what behavioral treatments have been attempted for the condition of insomnia, and no statement indicating how the patient has responded to Ambien treatment. Finally, there is no indication that Ambien is being used for short term use as recommended by guidelines. In the absence of such documentation, the currently requested Ambien 5 mg Qty 30, 1 tab by mouth every night as needed is not medically necessary.