

Case Number:	CM15-0041116		
Date Assigned:	03/11/2015	Date of Injury:	05/06/1998
Decision Date:	04/14/2015	UR Denial Date:	02/20/2015
Priority:	Standard	Application Received:	03/04/2015

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: Arizona, California
 Certification(s)/Specialty: Family Practice

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 47 year old female, who sustained a work/ industrial injury on 5/6/98. She has reported initial symptoms of bilateral upper extremity pain that was described as shooting, stabbing, tingling pain with increased sensitivity to touch and lower extremity pain with swelling into the right lower extremity and shooting pains bilaterally. The injured worker was diagnosed as having myalgia/myositis. Treatments to date included medication, home exercise program, and surgery: left wrist reconstruction (1998), removal of ulna bone from left wrist (1999). Currently, the injured worker complains of chronic lower extremity pain and insomnia. Diagnosis was complex regional pain syndrome (CRPS) of the upper/lower extremities. The treating physician's report (PR-2) from 1/21/15 indicated the pain was rated 9/10. Neck exam was negative. Medications included hydromorphone, Lyrica, Mometasone topical cream, diazepam, Tizanidine, Vistaril, and Ambien. Treatment plan was to renew medication to include Ambien due to chronic insomnia.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 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 (ODG), Treatment Index, 13th Edition (web), 2015, Pain Zolpidem (Ambien).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG- pain chapter- insomnia pg 64.

Decision rationale: The MTUS guidelines do not comment on insomnia. According to the ODG guidelines, insomnia medications recommend that treatment be based on the etiology, with the medications. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). In this case, the claimant had used the medication for several months. In this case, the claimant was noted to have 2 hours of sleep on 1/21/15. However, review of symptoms indicates no sleeping difficulties. The etiology of sleep disturbance was not defined or further evaluated. Use of Ambien beyond 10 days is not recommended and a 30-day supply as above is not medically necessary.