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| Case Number: | CM13-0014336 | | |
| Date Assigned: | 01/10/2014 | Date of Injury: | 02/11/2007 |
| Decision Date: | 03/19/2014 | UR Denial Date: | 08/05/2013 |
| Priority: | Standard | Application Received: | 08/20/2013 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine, and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 53-year-old female with date of injury on 02/11/2007. Progress report dated 07/08/2013 by [REDACTED] indicates that the patient's diagnoses include: (1) Impingement, right shoulder, with rotator cuff tendonitis, (2) Disk bulge, L4-L5 and L5-S1, (3) Right-sided sciatica. The patient continues with low back pain which radiates into the right leg. The patient also has pain in the right shoulder. Exam findings include mild restriction of range of motion in the right shoulder with tenderness above the rotator cuff. Neer's sign and Hawkin's test are positive. Weakness of the rotator cuff is noted. Lumbar spine has tenderness and spasm. There is restricted range of motion of the lumbar spine which reproduces pain. Straight leg raise is positive on the right. Decreased sensation is present at the dorsal aspect of the right foot. The patient is continued on Ambien 5 mg #60. Utilization review letter dated 08/05/2013 issued a non-certification for Ambien.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 5 mg Quantity 60: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-Treatment in Workers Comp (TWC), Chronic Pain Chapter online, Zolpidem.

Decision rationale: The employee continues with low back pain with associated radicular symptoms into the right lower extremity. The employee also has right shoulder pain. The employee appears to be on Ambien for chronic use. The records appear to indicate that the employee has been on this medication as far back as 01/14/2013. The MTUS guidelines are silent on the use of Ambien for insomnias. Therefore, the ODG Guidelines were reviewed which indicate that zolpidem is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually 2 to 6 weeks) treatment of insomnia. The treating physician does not provide documentation that indicates the employee has significant complaints of insomnia. The employee appears to have been on Ambien for chronic use which is not supported by the guidelines noted above. Therefore, recommendation is for denial.