

Case Number:	CM14-0135892		
Date Assigned:	09/03/2014	Date of Injury:	11/09/2012
Decision Date:	09/29/2014	UR Denial Date:	07/25/2014
Priority:	Standard	Application Received:	08/22/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, 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 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/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 injured worker is a 37 year old female with a reported date of injury on 05/08/2013. The injury reportedly occurred while lifting a heavy object. The diagnoses included enthesopathy of the left wrist. The past treatments included pain medication, a left wrist brace, and physical therapy. An MRI of the left wrist performed on 07/10/2014 revealed a non-displaced fracture. On 06/16/2014, the subjective complaints included pain in the left wrist, anxiety, and insomnia. The physical examination noted decreased range of motion in left wrist and pain. The injured worker's medications were listed as Norco, Flexeril, Naproxen, Ambien, and Protonix. The treatment plan was to continue medications. The rationale was to relieve pain and improve sleep. The request for authorization form was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10mg #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, Pain, 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), Pain, Ambien (Zolpidem Tartrate).

Decision rationale: The request for Ambien 10mg #60 no refill is not medically necessary. The Official Disability Guidelines state that Ambien is not recommended for long-term use, but recommended only for the short-term treatment of insomnia, not to exceed 6 weeks. The injured worker has chronic pain and insomnia. The notes indicate that she has been on Ambien since at least 06/03/2013 which exceeds the guideline recommendation of 6 weeks. Additionally, the request as submitted did not provide a medication frequency. Since the injured worker has been on Ambien longer than 6 weeks the request is not medically necessary.