

Case Number:	CM14-0145610		
Date Assigned:	09/12/2014	Date of Injury:	01/03/2012
Decision Date:	10/30/2014	UR Denial Date:	08/29/2014
Priority:	Standard	Application Received:	09/08/2014

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 Physical Medicine and 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 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 patient is a 42 year old with an injury date on 1/3/12. The patient complains of bilateral wrist pain rated 7/10 with numbness/tingling per 8/19/14 report. The patient had 5 sessions of physical therapy since surgery, but the effectiveness is not mentioned in 8/19/14 report. The patient also reports difficulty sleeping per 8/19/14 report. Based on the 8/19/14 progress report provided by [REDACTED], the diagnoses include status post right trigger finger release, status post left trigger finger release, status post left carpal tunnel release, right tennis elbow and status post right wrist arthroscopic triangular fibrocartilage complex debridement and percutaneous right lateral epicondyle release. An exam on 8/19/14 showed "range of motion of right wrist showed slightly diminished range of motion in extension at 45/60, and left wrist range of motion showed 55/60 in extension." The patient's treatment history includes physical therapy, a home exercise program and medications (Anaprox, Norco). [REDACTED] is requesting Ambien 5mg #30 refill. The utilization review determination being challenged is dated 8/29/14 and denies request due to lack of guidelines support for ongoing use beyond 4 weeks. [REDACTED] is the requesting provider, and he provided treatment reports from 1/10/14 to 8/19/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

AMBIEN 5MG #30 REFILL: 1 99070: 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), Chronic Pain, Insomnia Treatment, Ambien

Decision rationale: This patient presents with bilateral wrist pain. The physician has asked for Ambien 5mg #30 refill on 8/19/14. Regarding Ambien, ODG guidelines recommend for the short-term treatment (2 to 6 week period) of insomnia with difficulty of sleep onset (7-10 days). Not recommended for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. In this case, the physician has requested a "refill" of Ambien which implies prior usage. As ODG does not recommend long-term (beyond 7-10 days), the requested Ambien 5mg #30 refill is not considered medically necessary for this type of condition. Therefore the request is not medically necessary.