

Case Number:	CM15-0009072		
Date Assigned:	01/27/2015	Date of Injury:	10/19/2011
Decision Date:	03/24/2015	UR Denial Date:	01/08/2015
Priority:	Standard	Application Received:	01/15/2015

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, Arizona
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 54-year-old male who reported an injury on 10/19/2011. The mechanism of injury was not specifically stated. The current diagnoses include rotator cuff disorder, radiculopathy, hip bursitis, and lumbar facet syndrome. The injured worker presented on 12/18/2014, with complaints of 9/10 increasing low back, right shoulder, and right hip pain. The current medication regimen includes Dexilant 60 mg, Ambien 10 mg, Naprosyn 500 mg, and Ultram 50 mg. Upon examination of the lumbar spine there was limited and painful range of motion, paravertebral muscle spasm, and tenderness. Examination of the right shoulder revealed an open surgical scar over the anterior right shoulder, 4 inches in length, restricted range of motion, and negative Yergeson's test. Examination of the right hip revealed restricted and painful range of motion with negative faber testing. Motor examination revealed 4/5 weakness in the right lower extremity. On sensory examination, light touch sensation was decreased over the L4 and S1 distributions on the right side. Straight leg raising was positive on the right side. It was noted that the injured worker was status post right shoulder full thickness open rotator cuff repair. Recommendations at that time included continuation of the current medication regimen.

IMR ISSUES, DECISIONS AND RATIONALES

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

One prescription for Ambien # 20 with one refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG) 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) Chronic Pain Chapter, Insomnia Treatment.

Decision rationale: The Official Disability Guidelines recommend insomnia treatment based on etiology. Ambien is indicated for short term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. According to the documentation provided, the injured worker has utilized Ambien since at least 09/2014. Guidelines do not recommend long term use of this medication. The injured worker does not maintain a diagnosis of insomnia disorder. There is no documentation of an attempt at nonpharmacologic treatment for insomnia prior to the initiation of a prescription product. There is no strength or frequency listed in the request. Given the above, the request is not medically appropriate.