

Case Number:	CM15-0011548		
Date Assigned:	01/29/2015	Date of Injury:	06/23/2010
Decision Date:	03/24/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/21/2015

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

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

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 49 year old female with an industrial injury dated June 23, 2010. The injured worker diagnoses include status post avulsion fragment of the head of the third metacarpal bone, complex regional pain syndrome of right upper extremity with associated proximal cervical myofascitis, post concussion head injury with persistent headache/dizziness, medication induced gastritis, sleep disorder and overuse syndrome left upper extremity. She has been treated with diagnostic studies, radiographic imaging, prescribed medications, TENS unit device and periodic follow up visits. According to the progress note dated 11/25/14, the treating physician noted that the injured worker presented for a follow up visit complaining of right upper extremity pain radiating to the shoulder and to the chest wall with associated burning, tingling, and numbness. The injured worker also complained of occasional discoloration at the wrist and edema of the wrist. Objective findings revealed diffuse hypoesthesia to pinwheel in the right upper extremity. The treating physician prescribed Ambien 10mg #30 for sleep disturbance. Utilization Review determination on December 23, 2014 denied the request for Ambien 10mg #30, citing MTUS Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10mg #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 Pain Chapter, Insomnia Treatment

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain Chapter, Insomnia Treatment

Decision rationale: Regarding the request for Ambien, California MTUS guidelines are silent regarding the use of sedative hypnotic agents. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there is no clear description of the patient's insomnia, no statement indicating what behavioral treatments have been attempted, and no statement indicating how the patient has responded to treatment. Furthermore, there is no indication that the medication is being used for short-term treatment as recommended by guidelines. In the absence of such documentation, the currently requested Ambien is not medically necessary.