

Case Number:	CM15-0016701		
Date Assigned:	02/05/2015	Date of Injury:	11/14/2001
Decision Date:	03/30/2015	UR Denial Date:	01/06/2015
Priority:	Standard	Application Received:	01/29/2015

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

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 39-year-old female who reported an injury on 11/14/2001. The mechanism of injury was not stated. The current diagnoses include status post failed intrathecal pump trial, status post failed spinal cord stimulator trial, long term use of opioid medication, CRPS in the left lower extremity, status post left total knee arthroplasty on 01/27/2015, and renal colic. The injured worker presented on 12/19/2014, with complaints of low back pain, knee pain and hip pain. The injured worker also reported activity limitation. The current medication regimen includes Prilosec, naproxen, Lyrica, Celebrex, Cymbalta, docusate sodium, doxepin, Fentora, Keppra, OxyContin, Percocet, Zantac, Senna, Ambien, clonazepam, and Seroquel. Upon examination, there was full range of motion of the right knee, decreased range of motion of the left knee, asymmetrical flexion contractures, and intact sensation. Recommendations included continuation of the current medication regimen, as well as a topical cream for pain relief. It was noted that the injured worker may benefit from a functional restoration program, to aid in a reduction of pain medications. A Request for Authorization form was then submitted on 12/19/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10 MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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 the etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. The injured worker has continuously utilized the above medication for an unknown duration. The guidelines do not recommend long-term use of Ambien. There is also no documentation of a failure of nonpharmacologic treatment prior to the initiation of Ambien. There is no frequency listed in the request. Given the above, the request is not medically appropriate.