

Case Number:	CM15-0061615		
Date Assigned:	04/07/2015	Date of Injury:	08/25/2010
Decision Date:	05/06/2015	UR Denial Date:	03/05/2015
Priority:	Standard	Application Received:	04/01/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

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 45-year-old male, who sustained an industrial injury on 8/25/10. He reported initial complaints of right wrist pain from trauma. The injured worker was diagnosed as having right carpal tunnel syndrome, volar wrist ganglion, and right mild symptomatic thoracic outlet syndrome. Treatment to date has included medication, surgery (right wrist arthroscopic debridement of a triangular fibrocartilage complex tear on 5/16/11 and diagnostic wrist arthroscopy with distal radial ulnar joint fusion with ulnar nerve release on 7/1/13), physical therapy, bracing, steroid injections, and acupuncture. Nerve conduction studies were performed on 7/28/14. Currently, the injured worker complains of right ulnar wrist pain. Per the primary physician's progress report (PR-2) from 2/4/15, there was noted pain at 2/10 with medication and 8/10 without medication. Per examination, there was limited range of motion, prominence distal ulna dorsally, and decreased sensation in the right upper extremity. Current plan of care included medication and home exercise program. The requested treatments include Ambien.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 5mg #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 (ODG), Zolpidem (Ambien).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, insomnia.

Decision rationale: The California MTUS and the ACOEM do not specifically address this medication. Per the official disability guidelines recommend pharmacological agents for insomnia only is used after careful evaluation of potential causes of sleep disturbance. Primary insomnia is usually addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. Pharmacological treatment consists of four main categories: Benzodiazepines, Non-benzodiazepines, Melatonin and melatonin receptor agonists and over the counter medications. Sedating antidepressants have also been used to treat insomnia however there is less evidence to support their use for insomnia, but they may be an option in patients with coexisting depression. The patient does have the diagnosis of insomnia. The prescribed medication is indicated in the treatment of insomnia. However, ambien is not recommended for use greater than 6 weeks. Therefore, the request is not medically necessary.