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| <b>Case Number:</b>   | CM13-0030681 |                              |            |
| <b>Date Assigned:</b> | 11/27/2013   | <b>Date of Injury:</b>       | 06/24/2011 |
| <b>Decision Date:</b> | 02/27/2014   | <b>UR Denial Date:</b>       | 09/23/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/30/2013 |

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice 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 physician 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 43-year-old female who reported an injury on 06/24/2011. The patient is currently diagnosed with biceps tendinitis of the shoulder. The patient was recently seen by [REDACTED] on 08/16/2013. The patient reported complaints of constant pain and stiffness over the right shoulder with difficulty sleeping and constant headaches. Physical examination revealed palpable tenderness and effusion of the right shoulder with 85 degree flexion and 85 degree abduction. The patient also demonstrated decreased sensation in the upper extremities along the index, middle, and ring fingers on the right. Treatment recommendations included continuation of current medications. &ccedil;

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien (Zolpidem) 5 mg, # 60:** 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) Chronic Pain Chapter, Insomnia Treatment.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic)

**Decision rationale:** Official Disability Guidelines state Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset for 7 days to 10 days. Empirically supported treatment includes stimulus control, progressive muscle relaxation, and paradoxical intention. As per the clinical notes submitted, the patient has been continuously utilizing this medication. There has been no evidence of functional improvement in terms of the patient's reported sleep issues. It was documented on 08/16/2013 the patient noted difficulty sleeping. Satisfactory response to treatment has not been indicated. As guidelines do not recommend long term use of this medication, the current request cannot be determined as medically appropriate. Additionally, there is no evidence of a failure to respond to non-pharmacological treatment. The current request is non-certified.