

<b>Case Number:</b>	CM13-0046847		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	02/14/2002
<b>Decision Date:</b>	04/24/2014	<b>UR Denial Date:</b>	10/03/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/01/2013

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pediatric Rehabilitation Medicine and is licensed to practice in Texas. 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/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 52-year-old male without reported an injury on 02/14/2002. The mechanism of injury was not specifically stated. The patient is diagnosed as status post ACL reconstruction with meniscectomy and chondroplasty on 06/27/2011, disc herniation in the lumbar spine, status post fusion at L5-S1 with resolution of lower extremity neuropathic pain and weakness, right knee pain, and hardware removal in 03/2012. The patient was seen by [REDACTED] on 10/04/2013. The patient reported stiffness, radicular pain in bilateral lower extremities, and hip pain. Physical examination on that date revealed 5/5 motor strength, normal muscle tone, tenderness across the lumbosacral area of the spine with radiation into the right buttock and knee, good coordination, and normal proprioception sensations. The treatment recommendations at that time included continuation of current medications with a tapering of Nuvigil.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**30 tablets of Ambien, three refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers' Compensation, Online Edition, Chapter: Pain.

**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:** Official Disability Guidelines state insomnia treatment is recommended based on etiology. Ambien is indicated for short-term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. As per the documentation submitted, the patient has utilized Ambien 10 mg at bedtime since at least 01/2013. However, there is no documentation of chronic insomnia or sleep disturbance. There is also no indication of functional improvement as a result of the ongoing use of this medication. Official Disability Guidelines further state empirically supported treatment includes stimulus control, progressive relaxation, and paradoxical intention. There is no evidence of a failure to respond to nonpharmacologic treatment prior to the initiation of a prescription product. As guidelines do not recommend long-term use of this medication, the current request cannot be determined as medically appropriate. Additionally noted, there is no dosage or frequency stated in the current request. Based on the clinical information received and the Official Disability Guidelines, the request is non-certified.