

<b>Case Number:</b>	CM14-0108064		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	06/06/2005
<b>Decision Date:</b>	09/09/2014	<b>UR Denial Date:</b>	06/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/11/2014

### 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 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 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 injured worker is a 58-year-old who reported an injury on June 6, 2005 when he leaned over and pulled his back while working on a scissor lift. On June 10, 2014, the injured worker presented with pain rated 9 out of a 10 and states that medications are less effective. Current medications included Ambien and Nucynta. Diagnosis were status post posterior lumbar interbody fusion L5-S1 on December 13, 2005, intractable pain syndrome, left sacroiliitis, status post radiofrequency ablation of the left SI joint, September 10, 2007, lumbar spondylosis L4-5, and status post removal of hardware L5-S1, with intraoperative documentation of osseous fusion, on January 30, 2007. Upon examination of the lumbar spine, there was a well healed surgical scar, restricted range of motion, and tenderness over the paravertebral muscles with trigger points notated on the right side. The provider recommended Ambien. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien CR 12.5 mg, thirty count with five 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 Pain Chapter.

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

**Decision rationale:** The Official Disability Guidelines state Ambien is a prescription short acting nonbenzodiazepine hypnotic which is approved for short term, usually 2 to 6 week treatment of insomnia. He has been prescribed Ambien since at least December 25, 2013, which exceeds the guideline recommendation for short term treatment. As such, the request for Ambien CR 12.5 mg, thirty count with five refills, is not medically necessary or appropriate.