

<b>Case Number:</b>	CM14-0110220		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	07/07/1995
<b>Decision Date:</b>	09/17/2014	<b>UR Denial Date:</b>	06/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/15/2014

### 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 Orthopedic Surgery 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 56-year-old female who reported an injury on 07/07/1995, due to an unknown mechanism of injury. The injured worker reportedly sustained an injury to her bilateral upper extremities. The injured worker's treatment history included surgical intervention, postsurgical physical therapy and multiple medications. The injured worker was evaluated on 05/13/2013. It was documented that the injured worker had left shoulder pain and was currently working with restrictions. The injured worker's physical findings included restricted range of motion of the left shoulder with a positive impingement sign. The injured worker's diagnoses included complete tear of the rotator cuff of the left shoulder. The injured worker's medications included Norco 5/325 mg, Ambien 10 mg, omeprazole 20 mg and diclofenac 75 mg. A Request for Authorization was submitted on 05/15/2014 requesting a refill of medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien 10mg Quantity 90.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

**Decision rationale:** California Medical Treatment Utilization Schedule does not address insomnia treatments related to chronic pain. The ODG recommend a short duration of treatment with the use of Ambien. The clinical documentation indicates the injured worker has been on this medication since at least 02/2014. Additionally, the clinical documentation does not provide any assessment of the injured worker's sleep hygiene to support the efficacy of this medication. The injured worker has been on this medication for an extended duration, therefore continued use would not be indicated. The request, as it is submitted does not clearly identify a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. Therefore, the requested Ambien 10 mg quantity is not medically necessary or appropriate.