MAXIMUS Federal Services

| Case Number: | CM14-0134564 | | |
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| Date Assigned: | 08/25/2014 | Date of Injury: | 11/23/2007 |
| Decision Date: | 10/23/2014 | UR Denial Date: | 07/25/2014 |
| Priority: | Standard | Application Received: | 08/19/2014 |

## 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 & Rehabilitation, has a subspecialty in Pain Medicine, 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:

Records indicate this is a 37-year-old female patient who sustained an industrial injury on 11/23/2007. Patient is diagnosed with left posttraumatic thoracic outlet syndrome, left piriformis syndrome, and left adhesive capsulitis. Mechanism of injury occurred while working as a kitchen aide/manager when she sustained an acute injury to the left hand and shoulder as well as low back. She reportedly slipped and fell on water on the floor. She used her left hand in an attempt to break her fall. She fell on her buttocks but did not lose consciousness. Previous treatment has included medications, a wrist brace, and physical therapy. EMG/nerve conduction studies performed on 01/28/14 was reported to be abnormal for low-grade left medial cord brachial plexopathy or C8-T1 cervical radiculopathy by EMG. Most recent progress note provided is stated 06/02/14. The patient presented with subjective complaints of pain throughout the neck and left brachial region. There was noted a request had been submitted for authorization for a left brachial decompression with ulnar and median nerve decompression in the same setting. She remains on medications which she feels are helpful. Objective findings revealed gait is restricted and cane assisted. She has substantial left scalene tenderness, left brachial plexus Tinel, positive left costoclavicular abduction, left upper extremity weakness. There was moderate left piriformis tenderness and positive left FAIR test. Urine drug screen performed was negative for opiates and illicit substances. This was consistent with prescribed medications. Treatment plan included awaiting authorization for left brachial decompression as well as medication management including continue tramadol as needed for breakthrough pain, continue Azor 5/20 mg as needed for hypertension, Butrans patch 5 g one patch weekly, and Ambien 10 mg as needed at night for sleep disturbance. A request for Ambien 10 mg was non-certified as a utilization review on 07/14/14 with the reviewing physician noting that Ambien is approved for the short-term (usually 2-6 weeks) treatment of insomnia. Today, the patient

continues to be prescribed Ambien. The records did not indicate the patient has been encouraged to use good sleep hygiene techniques.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien 10mg:** 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) Mental Health and Stress, Insomnia Treatment

**Decision rationale:** Regarding Zolpidem, the ODG guidelines indicate that Zolpidem is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Although this medication can provide short-term benefit, these agents are not recommended for long-term use, as they can be habit forming and may impair function and memory. Over the long-term, they may increase pain and depression. Given duration of use appears to exceed the recommended 2-6 week use, ongoing utilization of this medication is not indicated or supported as medically necessary. There is further no description of failed first-line treatment options for insomnia such as sleep hygiene/relaxation techniques or over-the-counter sleep medications. The current request does not specify frequency of dosing or quantity requested. Therefore, the request for Ambien 10 mg (unknown quantity) is not medically necessary.