

Case Number:	CM14-0158947		
Date Assigned:	10/02/2014	Date of Injury:	05/05/2005
Decision Date:	10/29/2014	UR Denial Date:	09/05/2014
Priority:	Standard	Application Received:	09/29/2014

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 Interventional Spine 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 patient is a 49-year-old female with date of injury of 05/05/2005. The listed diagnoses per [REDACTED] from 08/05/2014 are: 1. Lumbago. 2. Spasms of the muscles. 3. Degenerative lumbar/lumbosacral intervertebral disk. 4.

Thoracolumbosacral neuritis/radiculitis. According to this report, the patient complains of chronic low back pain with left leg pain. She does not report any significant change from her previous visit. The patient is taking all her medications as prescribed; however, she has had to pay cash for them. Her current medication regimen is stable and helpful. The patient complains of poor sleep quality due to pain. The patient rates her pain 8/10 to 9/10. The examination shows difficulty with standing and sitting. The patient does not use any assistive devices for ambulation. She has weakness and foot drop effect on the left lower extremity. There is decreased lumbar active range of motion. The utilization review denied the request on 09/05/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zolpidem Tartrate 10 mg # 30: 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) Zolpidem

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: This patient presents with chronic low back pain with left leg pain. The treater is requesting zolpidem tartrate 10 mg quantity 30. The MTUS and ACOEM Guidelines are silent with regards to this request. However, ODG Guidelines on zolpidem states "Zolpidem [Ambien (generic available), Ambien CR] is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Longer-term studies have found Ambien CR to be effective for up to 24 weeks in adults." The records show that the patient has been prescribed zolpidem since 04/15/2014. The 08/05/2014 report notes that the patient continues to complain of poor sleep quality due to pain. The treater does not discuss whether or not Ambien has been helpful. Furthermore, it would appear that this medication is prescribed longer than 7-10 days. ODG does not recommend long-term use of Ambien. The request is not medically necessary.