

<b>Case Number:</b>	CM14-0063512		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	06/29/2000
<b>Decision Date:</b>	08/08/2014	<b>UR Denial Date:</b>	04/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/06/2014

### 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: Family 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:

This injured worker's date of injury is 06/29/2000. The original injury to the lower back occurred when the patient experienced a fall from a ladder. The patient receives treatment for chronic low back pain with radiation down the left leg and lumbar strain. The treating physician's note dated 03/26/2014 states that the back pain and radiation down the left leg continues. A recent MRI shows a disc herniation at the left S1 nerve root. The patient will see a pain management specialist. On exam the low back reveals limited range of motion. Straight leg raising is positive with radiation down the left leg. Heel and toe gait is impaired. There is sensory loss on the left calf laterally and on the bottom of the left foot. Medications include Celebrex BID, Flector patches, Tylenol with codeine No. 3, Voltaren gel, and Ambien for sleep.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien 10mg, #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 (Ambien).

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

**Decision rationale:** This patient has chronic low back pain with radiculopathy. Ambien 10mg. refill is requested for chronic sleep disturbance; however, efforts at sleep hygiene, past use of medication, and any noted side effects are not included in the documentation. Zolpidem is medically approved for the short-term management of sleep disturbance, usually less than 4 weeks. Complex sleep-related side effects, eg. sleep driving, are known to occur with long-term use. The request for Ambien is not medically necessary.