

<b>Case Number:</b>	CM14-0148495		
<b>Date Assigned:</b>	09/18/2014	<b>Date of Injury:</b>	01/02/1998
<b>Decision Date:</b>	04/22/2015	<b>UR Denial Date:</b>	08/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/12/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Emergency Medicine

### 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 73 year old female/male, who sustained an industrial injury to his back on 1/2/98. The diagnoses have included lumbar disc displacement without myelopathy, post lumbar laminectomy syndrome, shoulder pain, muscle spasm, neuralgia and cervical radiculopathy. Treatment to date has included medications, surgery, diagnostics, injections, physical therapy and conservative measures. Surgery included lumbar hemilaminectomy 12/8/05, lumbar laminectomy 2002 and lumbar discectomy and decompression 1/13/00. Currently, as per the physician progress note dated 7/23/14, the injured worker complains of back pain that radiates down both legs with numbness. The back pain was rated 8/10 on pain scale with medications. The pain in the right knee was rated 10/10 with medications and activity and the left shoulder pain was 5/10 with medications. The injured worker reports that the pain is worse, quality of sleep is poor and activity level was the same. He also reports increased depression. He states that medications work well. Physical exam of the lumbar spine revealed restricted range of motion, spasm, tenderness and tightness. The straight leg raise was positive bilaterally. The current medications include Zoloft, Colace, Ambien, Metanx, Oxycontin, Norco and Lyrica. The physician requested treatment includes Ambien 10mg, #180 with 1 refill for sleep disturbance since the injury.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien 10mg, #180 with 1 refill:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Goodmand and Gilmans, The Pharmacological Basis of Therapeutics, 12th ed, McGraw Hill, 2010; Physician Desk Reference, 68th Ed.; www.RxList.com; and on the Official Disability Guidelines (ODG) Drug Fomulary.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Pain (Chronic): Insomnia Treatment.

**Decision rationale:** There is no specific sections in the MTUS chronic pain or ACOEM guidelines that relate to this topic. Ambien is a benzodiazepine agonist approved for insomnia. As per ODG guidelines, it recommends treatment of underlying cause of sleep disturbance and recommend short course of treatment. Long term use may lead to dependency. Patient has been on Ambien chronically. There is no documentation of other conservative attempts at treatment of sleep disturbance or sleep studies. The prescription is excessive and not consistent with short term use or attempts to wean patient off medication. The chronic use of Ambien is not medically appropriate and is not medically necessary.