

<b>Case Number:</b>	CM15-0011131		
<b>Date Assigned:</b>	01/29/2015	<b>Date of Injury:</b>	12/05/2009
<b>Decision Date:</b>	04/01/2015	<b>UR Denial Date:</b>	12/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2015

### 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: Family Practice

### 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 48-year-old male who reported an injury on 12/05/2009. The mechanism of injury was unspecified. His diagnoses included cervical discopathy, bilateral upper extremity overuse tendinopathy, lumbar sprain, anxiety, depression, gastrointestinal disturbance, left carpal tunnel syndrome and status post right carpal tunnel release. His past treatments included medication and surgery. On 12/05/2014, the injured worker complained of neck, bilateral wrists and low back pain. He also complained of shoulder pain rated 7/10 and left hand pain rated 8/10. Documentation indicated the injured worker was taking Ambien 10 mg for pain. The treatment plan included conservative therapy, continue with home exercise program and prescription for 10 mg. A rationale was not provided for review. The Request for Authorization form was submitted on 12/05/2014.

### 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) Pain Chapter; Insomnia Treatment.

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

**Decision rationale:** The request for Ambien 10 mg #30 is not medically necessary. California Medical Treatment Utilization Schedule does not address this medication. Official Disability Guidelines recommend this medication to assist with sleep restoration when an injured worker is experiencing insomnia due to chronic pain. The clinical documentation does indicate that the prescribed Ambien is helping with symptoms. However, this medication is recommended for short term use only. As the patient has been on this medication for an extended period of time, continued use is not supported. There is not documentation that an attempt to transition the patient off of this medication has been made. Furthermore, the request as it is submitted does not provide a frequency of use. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Ambien 10 mg #30 is not medically necessary or appropriate.