

<b>Case Number:</b>	CM15-0146909		
<b>Date Assigned:</b>	08/07/2015	<b>Date of Injury:</b>	06/12/2002
<b>Decision Date:</b>	09/04/2015	<b>UR Denial Date:</b>	06/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/28/2015

### 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: Arizona, 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 sustained an industrial injury on 6-12-02. He reported pain in his lower back. The injured worker was diagnosed as having lumbar radiculitis, post lumbar laminectomy syndrome and depression. Treatment to date has included a TENS unit and a spinal cord stimulator. Current medications include Norco, Ibuprofen, Prilosec and Ambien since at least 9-17-14. On 3-20-15 the injured worker indicated that the stimulator is functioning now; he is using it at night, it is not as effective and he need an adjustment. As of the PR2 dated 6-17-15, the injured worker reports low back pain that radiates to his legs and poor sleep. He rates his pain a 3 out of 10 at best and an 8 out of 10 with medications. The treating physician noted that the stimulator is not functioning. The treating physician requested Ambien 10mg #30.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 prescription of Ambien 10mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter and pg 64.

**Decision rationale:** The MTUS guidelines do not comment on insomnia. According to the ODG guidelines, insomnia medications recommend that treatment be based on the etiology, with the medications. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. Zolpidem is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). In this case, the claimant had used the medication for over a year. The etiology of sleep disturbance was not defined or further evaluated. Pain was likely the underlying factor for sleep disturbance. Continued use of Zolpidem (Ambien) is not medically necessary.