

<b>Case Number:</b>	CM15-0191797		
<b>Date Assigned:</b>	10/05/2015	<b>Date of Injury:</b>	10/02/1992
<b>Decision Date:</b>	11/12/2015	<b>UR Denial Date:</b>	09/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2015

### 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: Connecticut, California, Virginia  
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 54 year old female, who sustained an industrial injury on 10-2-92. The documentation on 9-4-15 noted the injured worker has complaints of lower back and spine pain with a pain level of 8 and neck pain with a level of 5. The injured worker reports having significant pain and trouble sleeping and only sleeping 1 to 2 hours at a time. The injured worker reports visual analog scale with medications is a 5 to 8 and without medications is a 7 to 8. The injured worker indicates an approximate 50 percent increase in the duration that she can sit, stand and walk with medication, compared to without her medications. Cervical range of motion forward flexion of 30 degrees, extension limited to 5 degrees and lumbar range of motion also markedly limited and there is a positive right straight leg raising sign. The diagnoses have included major depressive affective disorder recurrent episode severe degree without psychotic behavior; cervicgia; lumbago and sciatica. Medications were listed at ativan; buspirone; estrogen; lamictal; Lipitor; Norco; polyethylene glycol protonix and seroquel. The original utilization review (9-18-15) denied the request for ambien 5mg #30.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien 5mg #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) 2013 Online Version, Stress & Mental Illness Chapter, Zolpidem.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG insomnia, zolpidem.

**Decision rationale:** Ambien is indicated for short-term treatment of insomnia. Per the ODG Guidelines for Insomnia, Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). A more appropriate treatment, trazodone, was approved by utilization review. Therefore, Ambien in conjunction is unlikely to provide improvement in overall symptoms, and therefore the request is not medically necessary at this time.