

<b>Case Number:</b>	CM15-0023471		
<b>Date Assigned:</b>	02/13/2015	<b>Date of Injury:</b>	11/08/2008
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	01/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/09/2015

### 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, Arizona  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 62-year-old male who reported an injury on 11/03/2008. The mechanism of injury was not stated. The current diagnoses include lumbar postlaminectomy syndrome and lumbar disc displacement without myelopathy. The injured worker presented on 02/05/2015 for a followup evaluation with complaints of low back pain with radiation into the bilateral lower extremities. Upon examination, there was decreased sensation in the left L4 dermatome and positive straight leg raising bilaterally. There was spasm and guarding noted in the lumbar spine. Recommendations at that time included continuation of the current medication regimen of trazodone 50 mg, cyclobenzaprine 10 mg, Gabapentin 600 mg, Nucynta ER 150 mg, Ambien 10 mg, and Norco 10/325 mg. There was no Request for Authorization form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Zolpidem tartrate (Ambien) 10 mg:** 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), as well as Mosby's Drug Consultation.

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

**Decision rationale:** The Official Disability Guidelines recommend insomnia treatment based on etiology. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. In this case, there was no documentation of a failure to respond to non-pharmacologic treatment for insomnia. The injured worker does not maintain a diagnosis of insomnia disorder. Additionally, the request as submitted failed to indicate a frequency or quantity. Given the above, the request is not medically appropriate.