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| <b>Case Number:</b>   | CM15-0055186 |                              |            |
| <b>Date Assigned:</b> | 03/30/2015   | <b>Date of Injury:</b>       | 01/27/2009 |
| <b>Decision Date:</b> | 05/01/2015   | <b>UR Denial Date:</b>       | 03/16/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 03/23/2015 |

### 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: North Carolina, Georgia  
 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 57 year old female, who sustained an industrial injury on 01/27/2009. On provider visit dated 03/11/2015 the injured worker has reported chronic back pain and bilateral hip pain. On examination, she was noted tenderness in the lumbar spine at the lumbosacral junction. The diagnoses have included chronic pain syndrome, back pain, lumbar with radiculopathy, lumbar spine degenerative disc disease, lumbar spine degenerative facet disease, hips degenerative joint disease and chronic insomnia. Treatment to date has included medication. The provider requested a refill medication Ambien for symptom management.

### 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.

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

**Decision rationale:** The CA MTUS is silent on the use of Ambien. ODG addresses insomnia treatments in the section on pain. ODG states that treatment should be based on the etiology of the insomnia. Pharmacologic agents should be used only after a careful investigation for cause of sleep disturbance. Primary insomnia should be treated with pharmacologic agents while secondary insomnia may be treated with pharmacologic and/or psychological measures. It is important to address all four components of sleep -sleep onset, sleep maintenance, sleep quality and next day function. Ambien is not FDA approved for use greater than 35 days. In this case, there is no documentation of investigation of cause of the insomnia nor is the response to treatment with Ambien or to nonpharmacologic measures documented. Therefore, there is no documentation of the medical necessity of treatment with Ambien and the UR denial is upheld.