

<b>Case Number:</b>	CM15-0081756		
<b>Date Assigned:</b>	05/04/2015	<b>Date of Injury:</b>	07/20/2002
<b>Decision Date:</b>	06/05/2015	<b>UR Denial Date:</b>	04/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/28/2015

### 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: New Jersey, New York  
 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 64 year old female who sustained a work related injury July 20, 2002. Past surgical history included left hip replacement. According to a primary treating physician's progress report, dated March 31, 2015, the injured worker presented for a follow-up evaluation of back pain. She complains of stiffness and pains located in the lumbar area, upper back, and lower back. The pain is described as aching, sharp, stabbing, and shooting down legs with numbness, rated 8-9/10. The physician noted the injured worker fell July, 2014, after her back gave out. There are noted complaints of right and left hip pain and right elbow and right knee pain. Medication review revealed no side effects, aberrant behavior, and UDS of December, 2014, was within normal limits. Assessment is documented as chronic lumbosacral spine pain, discogenic, facet and likely mediated with secondary myofascial pain. She has received sacroiliac joint injections in 2010, 2011, and 2013, which provided the benefit of increasing her function and decreasing her pain. Treatment plan included evaluation for sacroiliac joint surgery and medications. At issue, is the request for Ambien 10mg (1) at sleep #30 with 3 refills.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien 10mg 1 HS #30 with 3 refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter.

**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, Ambien.

**Decision rationale:** The request for Ambien is not medically necessary. MTUS guidelines do not address the use of Ambien. As per ODG, Ambien is a hypnotic that is approved for short-term treatment of insomnia, from 2-6 weeks. It can be habit-forming and may impair function and memory. It may also increase pain and depression over the long-term. There is no documentation that patient has failed a trial of proper sleep hygiene. The risk of long-term use of Ambien currently outweighs benefit and is considered medically unnecessary.