

<b>Case Number:</b>	CM14-0141806		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	05/01/2006
<b>Decision Date:</b>	11/24/2014	<b>UR Denial Date:</b>	08/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/02/2014

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 55-year-old female with an injury date of 05/01/2006. Based on the 05/27/2014 progress report, the patient complains of neck pain, upper extremity pain, lower back pain, and knee pain. She has restricted range of motion and a positive Tinel's and Phalen's test. The 06/24/2014 progress report indicates that the patient has severe pain in her neck and shoulders as well as her knee. The 08/12/2014 report states that the patient has depression and gastritis in addition to her physical pain. She also has an antalgic gait and a positive straight leg raise. The patient's diagnoses include the following: 1. Status post arthroscopy, arthroscopic partial meniscectomy, internal derangement of knee. 2. Bilateral wrist tenosynovitis, cervical sprain and strain. 3. Chronic pain syndrome. The utilization review determination being challenged is dated 08/26/2014. Treatment reports were provided from 03/25/2014 - 08/12/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien 5mg 1 Qhd Prn #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-Treatment for Worker's Compensation, 12th edition, Pain (updated 7/10/14) Zolpiderm (Ambien)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress chapter, Insomnia treatment

**Decision rationale:** Based on the 08/12/2014 progress report, the patient complains of having pain in her neck, shoulder, knee, as well as depression and gastritis. The request is for Ambien 5 mg 1 q.h.s. p.r.n. #30. The patient has been taking Ambien as early as 03/25/2014. The MTUS and ACOEM Guidelines do not address the Ambien; however, ODG Guidelines state that Ambien is indicated for short term treatment of insomnia with difficulty of sleep onset, 7 to 10 days. ODG Guidelines does not recommend long term use of this medication. The patient has been taking Ambien as early as 03/25/2014 which exceeds ODG Guidelines. The request is not medically necessary.