

<b>Case Number:</b>	CM14-0142125		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	06/15/2009
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	08/08/2014
<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 Emergency Medicine and is licensed to practice in Texas. 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 injured worker is a 54 year old male with a reported date of injury on 06/15/2009. The mechanism of injury was a fall. The diagnoses included chronic back pain and left knee pain. The past treatments included pain medication, physical therapy, TENS unit and surgery. There were no diagnostic studies submitted for review. The surgical history included spinal fusion at the L5-S1 level. The subjective complaints on 05/19/2014 included low back pain that radiates to left leg with spasms. The physical examination noted decreased range of motion to lumbar spine and altered sensory loss to light touch and pinprick to the lateral left calf and bottom of his foot. The medications included Vicodin, Mobic, and Ambien. The notes indicate that he has been on Ambien since at least 03/18/2014. The plan was to continue and refill medications. A request was received for Ambien 10mg #30. The rationale was to provide insomnia relief. The request for authorization form was dated 05/21/2014.

### 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: Pain/Insomnia Treatment

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

**Decision rationale:** The request for Ambien 10mg #30 is not medically necessary. The Official Disability Guidelines state that Ambien is not recommended for long-term use, but recommended for short-term use not to exceed 6 weeks. The injured worker has chronic pain and insomnia. The notes indicate that he has been on Ambien since at least 03/18/2014 which exceeds the guideline recommendation of 6 weeks. Additionally the request as submitted did not provide a medication frequency. Since the injured worker has been on Ambien longer than 6 weeks, the request is supported. As such, the request is not medically necessary.