

<b>Case Number:</b>	CM15-0178186		
<b>Date Assigned:</b>	09/18/2015	<b>Date of Injury:</b>	09/06/2008
<b>Decision Date:</b>	10/23/2015	<b>UR Denial Date:</b>	09/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/10/2015

### 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: Arizona, California  
 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 51 year old female, who sustained an industrial-work injury on 9-6-08. A review of the medical records indicates that the injured worker is undergoing treatment for chronic discogenic low back pain, chronic low back pain, pain related insomnia and lumbar spondylosis. Medical records dated (3-23-15 to 9-3-15) indicate that the injured worker complains of low back pain and bilateral leg pain. The pain is rated 7 out of 10 on pain scale without medication and 3-8 out of 10 with medications. This has remained unchanged. The injured worker states that medications allow her to maintain activities of daily living (ADL) and functional activities and improve comfort and quality of life. The medical record dated 6-22-15 the physician indicates that Ambien assists with sleep initiation and maintenance and sleep is much improved with use of Ambien CR compared to Ambien IR. The physician also notes that attempts at utilizing a smaller dose have failed to provide adequate sleep initiation and maintenance. The medical records also indicate worsening of the activities of daily living. Per the treating physician report dated 8-3-15 the injured worker is permanent and stationary. The physical exam dated 9-3-15 reveals that the injured worker has pain affecting her activities of daily living (ADL) and the pain also affects her sleep. The lumbar exam reveals decreased range of motion with pain, diffuse tenderness to palpation and straight leg raise with low back pain. Treatment to date has included pain medication including Norco, Ambien since at least 3-23-15, pain management, activity modifications, and other modalities. The treating physician indicates that the urine drug test result dated 9-3-15 and 6-22-15 was consistent with the medication prescribed. The request for authorization date was 9-4-15 and requested service included Ambien CR 12.5mg #30, 1 refill. The original Utilization review dated 9-9-15 modified the request to Ambien CR 12.5mg #30 with no refills as there is no evidence of a thorough evaluation of the

injured worker's sleep complaints were performed or that there was an attempt at addressing sleep hygiene or non-pharmacologic methods for treatment of insomnia have been tried.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Ambien CR 12.5mg #30, 1 refill:** 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.

**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 and pg 64.

**Decision rationale:** The MTUS guidelines do not comment on insomnia. According to the ODG guidelines, recommend that treatment be based on the etiology, with the medications. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. Zolpidem is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). In this case, the claimant's sleep issues were related to pain rather than a primary sleep disorder. The prescribed amount for 2 months exceeds the safety limit recommended by the guidelines. The use of Zolpidem (Ambien) as above is not medically necessary.