

<b>Case Number:</b>	CM15-0094558		
<b>Date Assigned:</b>	05/21/2015	<b>Date of Injury:</b>	09/29/2001
<b>Decision Date:</b>	06/26/2015	<b>UR Denial Date:</b>	05/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/18/2015

### 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 53 year old male who sustained a work related injury September 29, 2001. According to a treating physician's progress notes, dated April 24, 2015, the injured worker presented with complaints of low back pain, right lower extremity pain and mid thoracic pain. He has weaned himself form Opana ER and is using Percocet as needed. He has pain around where he believes the spinal cord stimulator is located. He is working full duty with the ability to take his medication and rates his pain 8/10, without medication. There is tenderness noted throughout the thoracic paraspinal musculature and decreased sensation in the right lower extremity. Impression is documented as lumbar facet syndrome; L4-L5 moderate central narrowing with moderate facet changes and moderate foraminal narrowing, L2-L3, L3-L4, L5-S1 disc disease and a spinal cord stimulator implant; depression, chronic pain; GERD (gastroesophageal reflux disease; gastritis. The physician noted he is waiting acceptance into a detoxification program. Treatment plan included recommendation for thoracic x-rays and continued medication. At issue, is the request for authorization for Ambien.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien 10 mg Qty 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: Mental Illness & Stress - Zolpidem.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ODG and insomnia medication Page(s): 64.

**Decision rationale:** The MTUS guidelines do not comment on insomnia. According to the ODG guidelines, insomnia medications 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 (Ambien) is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). In this case, the claimant had used the medication for several months. The etiology of sleep disturbance was not defined or further evaluated. There was mention of depression and sleep dysfunction in recent notes without mention of behavioral interventions. Continued and chronic use of Ambien is not medically necessary.