

<b>Case Number:</b>	CM14-0119074		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	03/29/2012
<b>Decision Date:</b>	10/17/2014	<b>UR Denial Date:</b>	07/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/29/2014

### 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 Family Medicine 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 injured worker is a 55 year old female injured on 03/29/12 while attempting to carry a 55 gallon barrel of detergent when she felt immediate pain in the left shoulder. The injured worker was initially treated with physical therapy, medication management, and injections to the injured shoulder. Surgical history includes left knee surgery and a C4-5 fusion. The clinical note dated 06/05/14 indicated the injured worker presented complaining of low back pain, limited range of motion in the lumbar spine, and tingling and numbness to the bilateral lower extremity. The injured worker reported low back pain exaggerated with standing on uneven surfaces or standing from a sitting position without the aid from the upper torso. The injured worker rated the pain at 9/10. Objective findings included severe sacroiliac joint inflammation with signs and symptoms of radiculitis/radiculopathy to the posterior and lateral aspect of the thigh, Gaenslen's test/Patrick's/Fabre's test positive, sacroiliac joint thrust demonstrated severely positive. Diagnoses include lumbar musculoligamentous injury, lumbar paraspinal muscle spasm, lumbar disc herniation, lumbar radiculitis/radiculopathy in the lower extremities, and sacroiliitis of right sacroiliac joint. Medication list was not provided for review. The initial request for Ambien 10mg #30 refills #5 was initially non-certified on 07/08/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ambien 10 mg #30 Refills: 5:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (web), 2013, Pain, Zolpidem (Ambien); Feinberg, 2008; Morin, 2009; Halas, 2006

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

**Decision rationale:** As noted in the Pain (Chronic) of the Official Disability Guidelines (ODG) - online version, Ambien is approved for the short-term (usually two to six weeks) treatment of insomnia. Pain specialists rarely, if ever, recommend it for long-term use. Ambien can be habit-forming, and may impair function and memory more than opioid pain relievers. There is also concern that it may increase pain and depression over the long-term. The request for 5 refills indicates the medication will be utilized on long-term basis, exceeding the recommended 2-6 week window of use. As such, the request for Ambien 10 mg #30 Refills: 5 is not medically necessary.