

<b>Case Number:</b>	CM14-0062246		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	07/09/2003
<b>Decision Date:</b>	08/18/2014	<b>UR Denial Date:</b>	04/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/05/2014

### 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 Psychiatry/ Geriatric Psychiatry/Addiction Psychiatry has a subspecialty in Psychiatry 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:

Records reviewed include 563 pages of administrative and medical records. The injured worker is a 44 year old male whose date of injury is 07/09/2003. His diagnosis is major depressive disorder, recurrent, moderate. He fell from a ladder 10-15 feet above the ground, striking his chest on the ladder during the fall. He sustained injury to the cervical and lumbar spine and left shoulder. He received chiropractic care, left shoulder arthroscopy in 08/06 and 10/07, L4-5 fusion on 05/03/07. Post operatively he underwent physical therapy and medication pain management. He developed headaches and depression, for which he was prescribed Cymbalta. This was ultimately not helpful. He was authorized for psychotherapy. By 01/2010 he was on Zoloft 50mg daily and said to be suffering from severe depression and anxiety attacks. In 02/2010 Serzone was increased, and Topamax 25mg and Ativan 0.5mg were added at bedtime for sleep and anxiety. He continued to suffer from pain and headaches. He had developed sleep apnea and used a CPAP machine. In 12/11 the impression was that he suffered from failed back syndrome. On 06/25/13 [REDACTED] (neurology) noted that the patient experiences 2-3 headaches per week accompanied by facial numbness. He had sharp, radiating pain in his neck, back, left arm and foot, and due to this uses a cane. He was noted to sleep poorly even with zolpidem 10mg (5-6 hours per night). On 01/29/14 he reported pain of 6/10 at neck with headaches, arm and low back pain. He had been given morphine in ER visits for his migraines and said that it worked for all of his pain. He was then given MS contin and Percocet for breakthrough pain. On 04/04/14 he was again seen at Acadia Pain Management by [REDACTED], who noted no depression or anxiety and no changes in mental status. Percocet was changed to oxycodone. [REDACTED] submitted a PR2 on 04/15/14. The patient attested to anxiety, frustration, and depression. He reported that he went to the ER for severe pain and chest pain in

April. Objectively he appeared depressed and hopeless. He denied suicidal ideation. He was diagnosed with severe depression. A PR2 of 06/17/14 by [REDACTED] (psychiatry) notes that the patient continues to suffer from frequent occipital headaches, and that his medications have not been sent since 05/22/14. Objectively he appears depressed, and he feels hopeless. He denied suicidal/homicidal ideation. Medications included Wellbutrin and Trazodone 100mg at bedtime for insomnia. [REDACTED] prescribed Ambien 10mg in April and May 2014. 06/11/14 medications prescribed by [REDACTED] for pain included oxycodone.

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

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

**AMBIEN 10MG 1 EVERY OTHER DAY #15 WITH 3 REFILLS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES.

**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, Zolpidem.

**Decision rationale:** The patient was diagnosed with major depressive disorder, recurrent, moderate. His psychiatrist, [REDACTED], is prescribing Wellbutrin for his depression however it is unclear from progress reports how effective this medication has been. The patient does not appear to have any functional improvement. There are no scales with which to compare different time frames. The request is for Ambien, presumably for sleep disruption. There is no evidence that any insomnia work up was done in records provided for review. The patient does have obstructive sleep apnea and has been prescribed a CPAP machine. Insomnia is one of the hallmark symptoms of depression, reassessing the patient's current medication regimen with the consideration of making changes could feasibly alleviate this problem. In addition, sleep disruption would undoubtedly be caused by the patient's ongoing description of his pain, which is apparently only partially relieved by medication. Beyond the factors already mentioned, the patient has already been prescribed Trazodone at bedtime, which is also used to aid in sleep. There is no rationale given for prescribing two medications for sleep. There is no evidence in records reviewed that the patient was educated regarding proper sleep hygiene. Given all of this information, Ambien is not medically necessary at this time and this request is noncertified. CA-MTUS does not reference Ambien/zolpidem. Per ODG, Zolpidem is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. (Feinberg, 2008)