

<b>Case Number:</b>	CM14-0165827		
<b>Date Assigned:</b>	10/10/2014	<b>Date of Injury:</b>	10/18/2007
<b>Decision Date:</b>	11/12/2014	<b>UR Denial Date:</b>	09/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/08/2014

### 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 & Neurology, Addiction Medicine, has a subspecialty in Geriatric 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 311 pages of medical and administrative records. The injured worker is a 63 year old female whose date of injury is 10/18/2007. Her diagnoses are chronic pain due to trauma, depressive disorder NOS, and insomnia unspecified. She had lifted a file basket which was too full from an overhead shelf. Her left wrist hyperextended and snapped, causing immediate pain. She was treated with a splint and underwent left carpometacarpal joint resection arthroplasty in 04/2008, with continued pain and weakness. She received physical therapy and injections. She subsequently developed compensatory right hand problems. She developed depression, anxiety, and difficulty sleeping related to chronic pain. There was concern about her coping skills and she was approved for psychologist/psychiatrist pain management around 2008-2009. Ambien appears to have been initially prescribed around 11/2008 then was denied in 2009. It is unclear if she continued on this medication, or if she stopped and was restarted at some point. She was on fluoxetine, which was changed to Wellbutrin in 05/2009, then switched to Zoloft in 2010. She had reported that Ambien makes her sleep walk. She was on Soma, which was felt to have possibly compounded her depression. In a psychiatric AME of 06/05/10 the patient reported that she had initial and mid-sleep cycle disturbance. Her appetite was variable with weight gain. She felt depressed and anxious. She had stopped her narcotics and was using medical marijuana. Inconsistencies were noted in her history given to other physicians vs. that given in her deposition, as well as between history in this AME and a questionnaire given to her therein. She was given the diagnosis of adjustment disorder with mixed anxiety and depressed mood, cannabis abuse, and malingering. Following this, in 2011, the patient was on Zoloft, Lexapro, and Cymbalta. Abilify was added, and at some point Latuda. No anxiety was mentioned. She was placed on a 5150 hold in 10/2011 for suicidal ideation with

plan, and was treated with Celexa, Seroquel, Norco, Prilosec, and Soma. Discharge diagnosis was bipolar II. There is a pain management progress note of 08/27/13 mentioning Xanax but indicating that the patient was negative for anxiety. A progress report of 05/27/14 by [REDACTED] (psychiatrist) indicated that the patient was seen for anxiety and depression with sleep disturbance due to her work related injury. Medications included Lexapro 40mg per day, Latuda 20mg per day, Xanax 1mg twice per day, Ambien 10mg, and Seroquel XR which was increased to 100mg in the evening. Latuda was discontinued. On 08/19/14 [REDACTED] noted that her sadness had improved, affect was good, and she was feeling more positive. She had no self-harm thoughts, no psychotic ideation, and insight and judgment were fair.

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

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

**Xanax 1mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24 of 127.

**Decision rationale:** While the patient is referred to as anxious, and in [REDACTED] office notes he indicates that the patient was being seen for anxiety, depression, and sleep disturbance related to her industrial injury, there were no subjective symptoms reported by the patient nor were there objective reports described of any type of anxiety. Furthermore, per MTUS, benzodiazepine guidelines limit use to 4 weeks. This patient has been prescribed Xanax since at least 05/27/14, possibly as far back as August 2013-well beyond the 4 week guideline. MTUS: Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. (Baillargeon, 2003) (Ashton, 2005) Therefore, the request is not medically necessary.

**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, Zolpidem (Ambien)

**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 initially prescribed Ambien in 2008. It was denied in 2009, and records are unclear as to whether or not she continued on or if it was restarted at some point thereafter. In any case, Ambien was clearly prescribed for far beyond the 2-6 week guideline for treatment of insomnia. In addition, although the patient had certification for psychological treatment, no records were provided to show that other treatment strategies were attempted such as sleep hygiene instruction, or learning coping strategies towards pain management. MTUS does not address Ambien (zolpidem). Per ODG, zolpidem is not recommended for long-term use, but recommended for short-term use. Zolpidem is approved for the short-term (usually two to six weeks) treatment of insomnia. 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. Doctors should look at alternative strategies for treating insomnia such as sleep hygiene. The report stresses that zolpidem should be used safely for only a short period of time. (SAMHSA, 2013) Therefore, the request is not medically necessary.