

Case Number:	CM15-0170115		
Date Assigned:	09/10/2015	Date of Injury:	07/08/2009
Decision Date:	10/08/2015	UR Denial Date:	07/31/2015
Priority:	Standard	Application Received:	08/28/2015

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: California

Certification(s)/Specialty: Internal Medicine

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 64-year-old male, who sustained an industrial injury on 7-8-2009. The injured worker was diagnosed as having posttraumatic cephalagia with vertigo, carpal and cubital tunnel syndrome, visual and hearing loss, cervical radiculopathy, probable rotator cuff impingement, and mood disturbance. He is not working and is on permanent disability, headache, cervical pain, cervicgia, lumbago, low back pain. The request for authorization is for: Zolpidem 10mg, one by mouth at bedtime for 30 days #30. The UR dated 7-30-2015, modified certification of Zolpidem 10mg, one by mouth at bedtime #10 to wean off over one month. On 2-2-2015, he is reported to be followed for head injury with resultant encephalopathy, carpal tunnel syndrome, cubital tunnel syndrome, visual loss due to retinal detachment in the left eye, diplopia, migraine, hearing loss, mood disturbance, and chronic pain syndrome. On this date he reported continued neck and shoulder pain. The provider noted that a magnetic resonance imaging of the cervical spine showed degenerative changes with spondylosis. He is also reported to be taking up to 3 Vicodin daily, as well as, Ambien and Gabapentin. He reportedly has severe vertigo and hearing loss. Physical findings revealed mild dysphoria, hard of hearing, pupils equal and reactive to light and accommodation, decreased vision of left eye, sensation intact in the face, Spurlings sign positive in the right arm, abduction of right shoulder is limited with atrophy and weakness noted. There is notation of full range of motion to the left shoulder, and no weakness in the lower extremities. He ambulates without difficulties, and is Romberg positive. On 5-14-2015, he reported headaches every day. Medications are reported to be helpful. He also reported neck pain worsened by prolonged sitting or standing. He is noted to have a normal beck depression test, mood disorder questionnaire is negative, ADHD

testing is negative, social phobia test is negative, and anxiety inventory is negative. He rated his current pain 6 out of 10 with medications. Physical findings revealed limited range of motion to the head and neck, tenderness of the lumbar spine with diminished range of motion, upper extremities noted no cyanosis, clubbing or edema. On 7-15-2015, he reported ongoing headaches, and neck pain. His Zolpidem is noted to have been modified by insurance. He rated his pain 6 out of 10 with medications and 8 out of 10 without medications. He is able to cook, do laundry, and garden. He reported insomnia and denied depression and anxiety. His behavior is noted as appropriate. The treatment to date has included magnetic resonance imaging of the cervical spine (6-25-2014), medications including: hydrocodone, Zolpidem and gabapentin, magnetic resonance imaging of the shoulder (date not documented), electro diagnostic studies (date not documented), therapy (amount not documented). There is a history of left hand carpal tunnel surgery, left eye surgery and cataract surgery. Diagnostic testing has included urine drug screen (4-1-2015, 5-14-2015, and 7-15-2015).

IMR ISSUES, DECISIONS AND RATIONALES

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

Zolpidem 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-Treatment in Workers' Compensation, Pain Chapter (updated 07/15/15).

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: Zolpidema.

Decision rationale: Based on ODG guidelines, Zolpidem is a prescription short acting non-benzodiazepine hypnotic, which is recommended for short-term (7-10 days) 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) See Insomnia treatment. Ambien CR offers no significant clinical advantage over regular release zolpidem. Ambien CR is approved for chronic use, but chronic use of hypnotics in general is discouraged, as outlined in Insomnia treatment. Ambien CR causes a greater frequency of dizziness, drowsiness, and headache compared to immediate release zolpidem. (Ambien & Ambien CR package insert) Cognitive behavioral therapy (CBT) should be an important part of an insomnia treatment plan. A study of patients with persistent insomnia found that the addition of zolpidem immediate release to CBT was modestly beneficial during acute (first 6 weeks) therapy, but better long-term outcomes were achieved when zolpidem IR was discontinued and maintenance CBT continued. (Morin, 2009) Due to adverse effects, FDA now requires lower doses for zolpidem. The dose of zolpidem for women should be lowered from 10 mg to 5 mg for IR

products (Ambien, Edluar, Zolpimist, and generic) and from 12.5 mg to 6.25 mg for ER products (Ambien CR). The ER product is still more risky than IR. In laboratory studies, 15% of women and 3% of men who took a 10-milligram dose of Ambien had potentially dangerous concentrations of the drug in their blood eight hours later. Among those who took Ambien CR, the problem was more common: 33% of women and 25% of men had blood concentrations that would raise the risk of a motor vehicle accident eight hours later. Even at the lower dose of Ambien CR now recommended by the FDA, 15% of women and 5% of men still had high levels of the drug in their system in the morning. (FDA, 2013) According to SAMHSA, zolpidem is linked to a sharp increase in ED visits, so it should be used safely for only a short period of time. In this case, the patient has been on Zolpidem far longer than is recommended. There was also a modified prescription for Zolpidem 10 mg #10 for use in weaning off of the medication in 6/2015. Therefore, based on ODG guidelines and the evidence in this case, the request for Zolpidem 10 mg #30 is not medically necessary.