

Case Number:	CM13-0024187		
Date Assigned:	03/14/2014	Date of Injury:	12/11/1996
Decision Date:	05/28/2014	UR Denial Date:	09/07/2013
Priority:	Standard	Application Received:	09/12/2013

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 Physical Medicine & Rehabilitation 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 patient has filed a claim for chronic low back pain associated with an industrial injury date of December 11, 1998. A utilization review from September 7, 2013 denied the request for tizanidine, topiramate due to no evidence of efficacy, and Lunesta due to no evidence of functional benefits. Treatment date has included lumbar epidural steroid injections, facet injections, opioid and non-opioid pain medications, home exercise program, and physical therapy. Medical records from 2013 were reviewed showing that the patient complains of chronic back pain but has continued to work. Prolonged positioning such as sitting for 30 minutes aggravates the pain. The patient is also diagnosed with mild sleep apnea and has been using a CPAP machine. Physical exam demonstrated lumbar spine tenderness to palpation with increased muscular tension in the right. Range of motion for the lumbar spine was decreased. Motor strength was mildly decreased with right foot dorsiflexors. Sensation was intact in the lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

TIZANIDINE HCL 4MG QTY: 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63 and 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63, 66.

Decision rationale: As stated on page 63 and 66 of the California MTUS Chronic Pain Medical Treatment Guidelines, Tizanidine is FDA approved for the management of spasticity with an unlabeled use for low-back pain. Muscle relaxant efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. In this case, the patient has been using Tizanidine since September 2012. However, the exact functional benefits such as increased performance of activities of daily living due to the use of this medication were not indicated in the documentation. Therefore, the request for Tizanidine is not medically necessary and appropriate.

TOPIRAMATE 25MG QTY: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 17, 21.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-22.

Decision rationale: As stated on page 16-22 of the California MTUS Chronic Pain Medical Treatment Guidelines, anti-epilepsy drugs are recommended for neuropathic pain. Outcomes with at least 50% reduction of pain are considered good responses while those with 30% reduction may consider another or additional agent. In this case, the patient has been on Topiramate since September 2012. However, it is unclear whether the use of this medication has resulted in functional benefits such as decreased pain scores and increased ability to perform activities of daily living. Continued use is contingent upon efficacy. Therefore, the request for Topiramate is not medically necessary and appropriate.

LUNESTRA 3MG 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.

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, INSOMNIA TREATMENT

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines, (ODG), Pain Chapter, Insomnia treatment was used instead. ODG states that Lunesta is a first-line medication for insomnia with potential for abuse and dependency. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. In this case, the patient was diagnosed with mild sleep apnea which may be a factor in the patient's sleep disturbance. The patient has been using Lunesta since September 2012. However, the exact functional benefits such as the ability to

have restful sleep were not indicated any documentation. Therefore, the request for Lunesta is not medically necessary and appropriate.