

Case Number:	CM13-0059683		
Date Assigned:	12/30/2013	Date of Injury:	11/23/2011
Decision Date:	04/04/2014	UR Denial Date:	11/01/2013
Priority:	Standard	Application Received:	12/02/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology has a subspecialty in Pain Management and is licensed to practice in Florida. 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 physician 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 is a 46-year-old female who reported an injury on 11/23/2011. The specific mechanism of injury was not provided. The patient's diagnosis was lumbosacral neuritis, unspecified. The patient's medication history included naproxen and tizanidine as of 01/2013 as well as zolpidem, with the earliest documentation in 07/2013. The documentation dated 08/19/2013 revealed that the patient had a Panel Qualified Medical Examination on 07/07/2013, in which the physician opined that the patient should have medications for sleep and Cymbalta as well as psychotherapy sessions and monthly psychiatric visits. The patient indicated that she had had right shoulder pain for the past several days, and she continued to have low back pain followed by left wrist pain that was the greatest complaint. The patient's diagnoses were noted to include a cervicothoracic sprain/arthrosis and possible neural encroachment, bilateral shoulder impingement syndrome with acromioclavicular joint arthrosis, bilateral carpal tunnel syndrome and DeQuervain's tenosynovitis, lumbosacral strain/arthrosis and possible neural encroachment and a bilateral feet and ankle sprain/strain as well as sleep disturbance and cephalgia. The plan included zolpidem 10 mg 1 at bedtime, tizanidine 2 mg as needed during the day and naproxen 550 mg twice a day as needed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zolpidem 10mg qhs: 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), Intergrated Treatment/Disability Duration Guidelines, Stress & Mental Illness Chapter

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, Ambien

Decision rationale: The Official Disability Guidelines indicate that Ambien is appropriate for the short-term treatment of insomnia, generally for 2 to 6 weeks. The clinical documentation indicated that the patient had been taking the medication since 07/2013. There was a lack of documentation of objective functional benefit that was received from the medication. Additionally, the request as submitted failed to indicate the quantity of the medication being requested. Given the above, the request for zolpidem 10 mg at bedtime is not medically necessary.

Tizanidine 2mg bid, prn: Upheld

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

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

Decision rationale: The California MTUS Guidelines indicate that muscle relaxants are prescribed as a second-line option for the treatment of acute low back pain. The usage should be less than 3 weeks. There should be documentation of objective functional improvement with the medication. The clinical documentation submitted for review failed to indicate that the patient had objective functional benefit from the medication and had muscle spasms. The patient was noted to be taking the medication for greater than 6 months, which is not supported by the guideline recommendations. The request as submitted failed to indicate the quantity of the medication being requested. Given the above, the request for tizanidine 2 mg twice a day as needed is not medically necessary.

Naproxen 550mg bid prn: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

Decision rationale: The California MTUS Guidelines indicate that NSAIDs are recommended for short-term symptomatic relief of low back pain. There should be documentation of an objective functional improvement and an objective decrease in the VAS score. The clinical documentation submitted for review indicated that the patient had been on the medication for an

extended period of time of greater than 6 months. There was a lack of documentation of objective functional improvement and an objective decrease in the VAS score. The request as submitted failed to indicate the quantity of the medication being requested. Given the above, the request for naproxen 550 mg is not medically necessary.