

Case Number:	CM14-0116612		
Date Assigned:	08/04/2014	Date of Injury:	03/29/2010
Decision Date:	09/17/2014	UR Denial Date:	06/19/2014
Priority:	Standard	Application Received:	07/24/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 injured worker is a 61-year-old female who has submitted a claim for degeneration of cervical and lumbosacral spine and chronic pain syndrome associated with an industrial injury date of April 21, 2010. The medical records from 2013 to 2014 were reviewed and showed that patient complained of chronic neck pain, shoulder pain, low back pain, left hip pain and pain to lower extremities. Pain was rated at 7 out of 10 with medications. Physical examination revealed moderate tenderness to palpation over the lumbar paraspinal musculature and mild diffuse tenderness over the sacroiliac joints. Examination of the cervical spine revealed tenderness to palpation over the cervical paraspinal musculature. There was tightness and tenderness over the bilateral trapezii and shoulders. Cervical range of motion was limited. Patient had a slow and antalgic gait but ambulated without the use of an assistive device. Treatment to date has included oral analgesics, opioids, aquatic therapy and acupuncture. Utilization review from June 19, 2014 denied the request for Flexeril 10 mg #90, Refills x3 because the request for Amrix 15mg #30, Refills x3, with the same generic Cyclobenzaprine, was modified to Amrix #30 with no refills and certified. The same review denied the request for Lunesta 3 mg @30, Refills x3 because its chronic use was not recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexeril 10 mg #90, Refills x3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics/Muscle Relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42.

Decision rationale: According to pages 41-42 of the CA MTUS Chronic Pain Medical Treatment Guidelines, sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. The addition of Cyclobenzaprine to other agents is not recommended. In this case, patient was started on Flexeril on August 2014. However, Amrix, with the same generic Cyclobenzaprine, was medically necessary for use by a previous review. Therefore, Flexeril 10mg #90, Refills x3 is not medically necessary.

Lunesta 3 mg #30, Refills x3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Eszopiclone (Lunesta), See Mental 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 Section, Lunesta.

Decision rationale: The CA MTUS does not specifically address Eszopiclone (Lunesta). Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG) was used instead. It states that Eszopiclone (Lunesta) is a non-benzodiazepine sedative-hypnotic (benzodiazepine-receptor agonist) and is a first-line medication for insomnia. It is a schedule IV controlled substance that has potential for abuse and dependency. Lunesta has demonstrated reduced sleep latency and sleep maintenance, and is the only benzodiazepine-receptor agonist FDA approved for use longer than 35 days. In this case, patient has been taking Lunesta since at least April 2014. Documentation failed to show if the medication has improved the quality of sleep of the patient. There was no discussion on sleep hygiene and trial of non-pharmacologic treatment. The clinical necessity of Eszopiclone was not established; therefore, the request for Lunesta 3 mg #30, Refills x3 is not medically necessary.

Amrix 15 mg #30, Refills x3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics.

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

Decision rationale: As stated on CA MTUS Chronic Pain Medical Treatment Guidelines pages 63-66, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. They may be effective in reducing pain and muscle tension, and increasing mobility. However, they show no benefit beyond NSAIDs in pain and overall improvement. Patient has been on this medication since at least January 2014 (8 months to date). This medication is not recommended for long-term use. Therefore, the request for Amrix 15 mg #30, Refills x3 was not medically necessary.

Zolpidem 10 mg #30, Refills x3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment 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) Pain Section, Zolpidem.

Decision rationale: The CA MTUS does not address Ambien (Zolpidem). Per the Strength of Evidence Hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (ODG) was used instead. The ODG states that Ambien (Zolpidem) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually 2 to 6 weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. In this case, the patient has been taking Ambien since at least January 2014 (8 months to date), which is clearly beyond the recommended duration of use. The documentation failed to show if the patient reports improvement in sleep from use of medication. There is no compelling indication concerning the need for variance from the guidelines. Therefore, the request for Zolpidem 10 mg #30, Refills x3 is not medically necessary.