

Case Number:	CM14-0030213		
Date Assigned:	06/20/2014	Date of Injury:	06/14/2012
Decision Date:	07/18/2014	UR Denial Date:	03/03/2014
Priority:	Standard	Application Received:	03/10/2014

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 Orthopedic Surgery 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 injured worker is a 59 year-old female who was reportedly injured on 6/14/2012. The mechanism of injury is noted as "work-related injury" which occurred in the performance of her usual duties. The most recent progress note dated 2/12/2014 indicates that there are ongoing complaints of low back pain that radiates down the bilateral lower extremities left greater than right. The pain is accompanied by numbness which is described as constant. She also complains of tingling and muscle weakness that is aggravated by activity to include standing and walking. The pain is rated as a 9 on a 0/10 intensity scale with medications. The pain is rated as a 10/10 on a 0-10 intensity scale without medications. Diagnostic imaging studies included a computerized tomography (CT) scan of the sacrum and coccyx dated 7/29/2013 which revealed severe degenerative changes CNET L5-S-1, probable impact fracture at S4-S5 with posterior displacement of the S5 segment and the attached coccyx. X-rays of the lumbar spine taken on 6/22/2013 revealed generalized osteopenia, Levoscoliosis and spondylosis of the lumbar spine, left orthopedic screws traversing the hip. X-rays sacrum and coccyx taken on 6/22/2013 revealed left femoral postsurgical changes, generalized osteopenia, poorly visualized sacral fracture of approximately the S3 level. X-rays of the thoracic spine taken on 11/27/2012 revealed evidence of generalized osteopenia with hypertrophic changes of the mid-and lower dorsal spine without evidence of fracture or destructive changes present. X-rays of the right wrist taken on 11/27/2012 revealed evidence of hyper trophic changes at the base of the first metacarpal bone. X-rays left knee 11/27/2012 revealed sclerotic area seen in the proximal tibia most consistent with a bone infarct. It patient has symptoms; a nuclear medicine bone scan is suggested. CT scan of the left hip without contrast performed on 11/19/2012 reveals 3 pins transfix a subcapital hip fracture. The fracture line is still lucent which raises the possibility of nonunion. Previous treatment includes medication: Norco 5/325, Gabapentin, Voltaren XR 1% gel, and Tizanidine HCL, and

epidural steroid injection, A request had been made for Tizanidine 4 mg, QTY: 30, Zolpidem 10 mg, QTY: 30, and was not certified in the pre-authorization process on 3/03/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tizanidine 4 mg, QTY: 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines (ODG) TWC, Pain Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Spasticity/Anti-spasmodic drugs Page 66 Page(s): 66-127.

Decision rationale: Tizanidine is a centrally acting alpha-2-adrenergic agonist that is Food and Drug Administration approved for management of spasticity. It is unlabeled for use in low back pain. Muscle relaxants are only indicated as a second line option for short-term treatment. It appears that medications are being used on a chronic basis which is against the guideline recommendations. There is no supporting documentation of failure of a first-line agent. Therefore this medication is not medically necessary.

Zolpidem 10 mg, QTY: 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines (ODG) TWC, Pain Procedure Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Non-MTUS Official Disability Guidelines (ODG), Pain (Chronic).

Decision rationale: Zolpidem is a short acting non-benzodiazepine hypnotic, which is approved for the short-term (usually 2-6 weeks) 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 specialist rarely, if ever recommend them for long-term use. This medication can be habit-forming, impair function, and memory. There is also concern that it may increase pain and depression over the long term. The nature of the patient's insomnia, or the efficacy or benefit this drug is provided in the past was unable to be determined after a review of the medical documentation. Therefore this request is deemed to be not medically necessary.