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| <b>Case Number:</b>   | CM14-0037853 |                              |            |
| <b>Date Assigned:</b> | 07/02/2014   | <b>Date of Injury:</b>       | 08/21/2003 |
| <b>Decision Date:</b> | 08/20/2014   | <b>UR Denial Date:</b>       | 03/20/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 03/31/2014 |

### 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 Internal Medicine and is licensed to practice in New York. 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 claimant is a 52 year old female who sustained an industrial injury on 08/21/2003. The injury occurred while lifting a television set. Her diagnoses include myofascial pain, myositis, and sciatica. She continues to complain of low back pain and on exam has decreased range of lumbar motion without motor or sensory deficits, sacroiliac compression test is positive. Treatment has included medical therapy, epidural steroid injections and physical therapy. The treating provider has requested a back brace, Ambien # 90, Zanaflex 4mg # 60 with 2 refills, and Zantac 150mg # 30 with 2 refills.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Back Brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

**Decision rationale:** There is no indication for a back brace. Per ODG lumbar supports is only indicated for fractures, spondylolisthesis, or documented instability, and there is no supportive evidence of their long-term effectiveness. There is no documentation of these issues in this

patient. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

**Ambien 10mg #90 with 2 refills:** 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 Other Medical Treatment Guideline or Medical Evidence: Medscape Internal Medicine- Treatment of Insomnia 2012.

**Decision rationale:** Ambien is a short-acting nonbenzodiazepine hypnotic indicated for the short-term treatment (two to six weeks) for managing insomnia. Long-term use is not recommended as there are associated risks of impaired function and memory with use more than opioids, as well as Ambien may be habit forming. There is no documentation provided indicating medical necessity for Ambien. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

**Zanaflex 4mg #60 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine (Zanaflex).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines California MTUS 2009 page 66 (pdf format) Page(s): 66.

**Decision rationale:** Tizanidine (Zanaflex) is a centrally acting alpha-2-adrenergic agent FDA approved for the treatment of spasticity; unlabeled use for low back pain. It is indicated for the treatment of chronic myofascial pain and as adjunct treatment for the treatment of fibromyalgia. Per California MTUS Guidelines muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory medications alone. The claimant has no reported lumbar spasm on exam. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

**Zantac 150mg #30 with 2 refills:** 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 Other Medical Treatment Guideline or Medical Evidence: Medscape Internal Medicine 2013: Ranitidine indications.

**Decision rationale:** There was no specific indication for Ranitidine use. the medication is used to treat ulcers, gastroesophageal reflux disease, esophagitis, Hypersecretory conditions (

Zollinger-Ellison syndrome), and stress ulcer prophylaxis. There was no clear detail provided in the available documentaiton as to why the medication is required, and there is no documentation of the claimant having any particular objective GI abnormalities. The patient has a history of peptic ulcer disease but is not on any NSAID therapy. The medical necessity for the requested item is not established. The requested item is not medically necessary.