

Case Number:	CM14-0047817		
Date Assigned:	07/02/2014	Date of Injury:	10/25/2010
Decision Date:	08/26/2014	UR Denial Date:	03/24/2014
Priority:	Standard	Application Received:	04/16/2014

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 Occupational Medicine 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 is a 30-year-old female who has submitted a claim for lumbar disc protrusion at L5-S1 with slight retrolisthesis at L5-S1, lumbar radiculopathy, lumbar spine strain, status post TLIF at L5-S1; associated with an industrial injury date of 10/25/2010. Medical records from 2014 were reviewed and showed that patient complained of persistent lumbar pain and lumbar radiculopathy. She describes her pain as sharp, throbbing, with shooting, stinging, stabbing, numbness and spasms. Pain is rated at 10/10 without medications, and 8/10 with medications. Physical examination showed tenderness to palpation over the upper, mid and lower paravertebral muscles. Range of motion is diminished and pain with lumbar extension. Treatment to date has included surgery, oral medications such as Norco, Ibuprofen, Zolpidem Tartrate and Tizanidine. Utilization review, dated 03/24/2014, denied the request for Ibuprofen because guidelines indicate that the use of NSAIDs may not be warranted long term, and can cause several side effects and should only be used acutely. The same review denied the request for Zolpidem tartrate as chronic use is not recommended. The request for Tizanidine is also not approved as they show no benefit beyond NSAIDs in treating pain and providing overall improvement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ibuprofen 800 mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 47. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 22, 46, and 72.

Decision rationale: As stated on pages 22, 46, and 72 of California MTUS Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and that there is no evidence of long-term effectiveness for pain or function. Long-term use of NSAIDs is not warranted. Ibuprofen can be taken for mild to moderate pain as 400 mg PO every 4-6 hours as needed. Doses greater than 400 mg have not provided greater relief of pain. In this case, medical records submitted show that the patient has been prescribed Ibuprofen since at least September 2013. However, long-term NSAID use is not recommended. Furthermore, guidelines do not support the use of doses greater than 400 mg. Moreover, the request failed to specify quantity to be dispensed. Therefore, the request for Ibuprofen 800mg is not medically necessary.

Zolpidem Tartrate 10 mg: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain, FDA - Ambien.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG), Pain, Zolpidem.

Decision rationale: The California MTUS does not address Ambien. 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 Official Disability Guidelines 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, Zolpidem was prescribed in March 2014 for insomnia. However, there was no discussion concerning sleep hygiene that may warrant such. Moreover, it was unclear if non-pharmacologic management had been attempted first. Therefore, the request for Zolpidem Tartrate 10 mg is not medically necessary.

Tizanidine HCL 4 mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine (Zanaflex, generic available) Page(s): 63-66.

Decision rationale: Page 63-66 of the California MTUS Chronic Pain Medical Treatment Guidelines state that Tizanidine is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity and off label use for low back pain. In addition, MTUS also states that muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. In this case, medical records submitted show that the patient has been prescribed Tizanidine since at least September 2013. However, the medical records do not clearly reflect continued functional benefit from its use. Long-term use is not supported by the guideline. The medical necessity has not been established. There was no clear rationale for continued use of this medication. Therefore, the request for Tizanidine HCl 4mg is not medically necessary.