

<b>Case Number:</b>	CM14-0085338		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	02/15/2006
<b>Decision Date:</b>	09/16/2014	<b>UR Denial Date:</b>	05/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/06/2014

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in Oklahoma & Texas. 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 55-year-old male who reported an injury on 02/15/2006. The mechanism of injury was not provided. On 05/20/2014, the injured worker presented with complaints of neck and low back pain. Upon examination of the cervical spine, there was tenderness to palpation over the C5-6 and tenderness to palpation over the paraspinal muscles. Examination of the lumbar spine noted tenderness to palpation over the L4-5 and paraspinal muscles. There was a positive bilateral straight leg raise. There is decreased sensation to the bilateral L5, bilateral S1, and L4 dermatomes. There was decreased sensation to light touch in the right upper extremity, right lower extremity, left upper extremity, and left lower extremity. Current medications included Fexmid, Omeprazole, and Zolpidem. Diagnoses were status post SCS implant, lumbar radiculopathy, cervical radiculopathy, post laminectomy syndrome of the lumbar region, displacement of the cervical intervertebral disc without myelopathy, lumbago, post laminectomy syndrome of the cervical region, and other acute reactions to stress. The provider recommended Fexmid and Zolpidem Tartrate. The provider's rationale was not provided. The Request for Authorization form was dated 06/02/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Fexmid 7.5mg #90:** Upheld

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

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

**Decision rationale:** The request for Fexmid 7.5 mg with a quantity of 90 is not medically necessary. California MTUS Guidelines recommend Fexmid as an option for short course of therapy. The effect of the medication is in the first 4 days of treatment, suggesting that shorter treatment courses may be better. The request for Fexmid 7.5 mg with a quantity of 90 exceeds the guideline recommendation of short term therapy. The provided medical documentation lacked significant objective functional improvement with the use of the medication and the provider's rationale was not provided within the documentation. Additionally, the provider's request did not indicate the frequency of the medication in the request as submitted. As such, the request is not medically necessary.

**Zolpidem Tartrate 10mg #30 with 3 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, Pain (Chronic): Zolpidem.

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

**Decision rationale:** The request for Zolpidem Tartrate 10 mg with a quantity of 30 and 3 refills is not medically necessary. The Official Disability Guidelines (ODG) states that Zolpidem is a prescription short acting non-benzodiazepine hypnotic which is approved for the short term, usually 2 to 6 week treatment of insomnia. Zolpidem is in the same drug class as Ambien. Proper sleep hygiene is critical to the individual with chronic pain and is often hard to obtain. Various medications may provide short term benefit. While sleeping pills, so called minor tranquilizers, antianxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long term use. They can be habit forming and may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long term. The provider's request for Zolpidem Tartrate 10 mg with a quantity of 30 and 3 refills exceed the guideline recommendation of short term use. Additionally, the provider's request does not indicate the frequency of the medication in the request as submitted. As such, the request is not medically necessary.