

Case Number:	CM14-0111078		
Date Assigned:	08/01/2014	Date of Injury:	01/29/2008
Decision Date:	04/14/2015	UR Denial Date:	06/27/2014
Priority:	Standard	Application Received:	07/16/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Texas, New York, California
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 applicant is a represented 50-year-old [REDACTED] beneficiary who has filed a claim for chronic low back pain reportedly associated with an industrial injury of January 29, 2008. In a Utilization Review Report dated June 27, 2014, the claims administrator failed to approve request for tizanidine, zolpidem, and prochlorperazine. The claims administrator referenced an RFA form dated June 12, 2014, in its determination. The claims administrator noted that the applicant had longstanding complaints of low back pain status post earlier lumbar laminectomy surgery. The applicant's attorney subsequently appealed. On April 4, 2014, the applicant reported persistent complaints of low back pain with ancillary radicular pain complaints. The applicant had undergone lumbar spine surgery in 2010. A 4/10 pain complaints were noted. The applicant is on OxyContin and tizanidine for pain relief. The applicant reported limited sitting, standing, walking tolerance on the order of the approximately 10 to 15 minutes continuously. The applicant stated that her overall health level was poor. Multiple medications were renewed. The applicant was apparently asked to continue current medications. The applicant's work status was not clearly detailed. On March 20, 2014, the applicant again presented with persistent complaints of low back pain. The applicant was asked to try and lose weight. The applicant was asked to continue OxyContin and Percocet. The applicant was using Percocet on a daily basis for breakthrough pain. The applicant was asked to employ Zofran for what appeared to be issues with opioid-induced nausea. The applicant was no longer smoking, it was stated. The applicant had pain complaints ranging from 3 to 7/10. The applicant's medication list included Abilify, Adderall, Catapres, Colace, Prozac, OxyContin, Percocet,

prochlorperazine, tizanidine, Zofran, and Ambien. It was suggested that the applicant was using Ambien nightly. The applicant had reportedly gained weight owing to her chronic pain issues. The applicant's height, weight and BMI were not, however, documented. The applicant work status was not detailed. In a January 2, 2014, psychiatric note, the applicant was asked to continue Prozac, Zofran, and Adderall. The applicant had reportedly alleged issues with traumatic brain injury (TBI), in addition to issues with depression. The attending provider stated that the applicant was not working, but was considering attending a rehabilitation course to try and facilitate her return to work.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tizanidine 4mg/tab #90 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63, 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASTICITY/ANTISPASMODIC DRUGS:Tizanidine (Zanaflex, generic available);Functional Restoration Approach to Chronic Pain Management;9792.20. Medical Treatment Utilization Schedule Definitions(f) Page(s): 66; 7.

Decision rationale: No, the request for tizanidine, an antispasmodic medication, was not medically necessary, medically appropriate, or indicated here. While page 66 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that tizanidine is FDA approved in management of spasticity but can be employed off labeled for low back pain as was/is present here, this recommendation, however, is qualified by commentary made on page 7 of the MTUS Chronic Pain Medical Treatment Guidelines to the effect that an attending provider should incorporate some discussion of medication efficacy into his choice of recommendations. Here, however, the attending provider failed to outline any meaningful or material improvements in function effected as a result of ongoing tizanidine (Zanaflex) usage. The applicant seemingly remained off of work, although it was acknowledged this was, in part, a function of the applicant's underlying psychopathology as opposed to a function of the applicant's chronic pain concerns alone. The applicant reported difficulty performing activities of daily living as basic as sitting, standing and walking. Ongoing usage of tizanidine failed to curtail the applicant's dependence on opioid agents such as OxyContin and Percocet. All of the foregoing, taken together, suggests a lack of functional improvement as defined in MTUS 9792.20f, despite ongoing usage of tizanidine. Therefore, the request was not medically necessary.

Zolpidem 10mg/tab #30: 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: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Approach to Chronic Pain Management Page(s): 7-8. Decision based on

Non-MTUS Citation NDA 19908 S027 FDA approved labeling 4.23.08 INDICATIONS AND USAGE: Ambien is indicated for the short-term treatment of insomnia characterized by difficulties with sleep initiation. Ambien has been shown to decrease sleep latency for up to 35 days in controlled clinical studies.

Decision rationale: Similarly, the request for zolpidem (Ambien), a sleep aid, was likewise not medically necessary, medically appropriate, or indicated here. While the MTUS does not specifically address the topic of Ambien usage, pages 7 and 8 of the MTUS Chronic Pain Medical Treatment Guidelines stipulates that an attending provider using a drug for a non-FDA labeled purposes has a responsibility to be well informed regarding the usage of the same, and should, furthermore, furnish clear or compelling evidence to support such usage. Here, however, the Food and Drug Administration (FDA) notes that Ambien is indicated in short-term treatment of insomnia, for up to 35 days. Here, however, the applicant has seemingly been employing Ambien (zolpidem) for what appears to be a minimum of several months. Such usage, however, is incompatible with the FDA label. The attending provider did not furnish any clear or compelling applicant specific rationale or medical evidence to support such usage. Therefore, the request was not medically necessary.

Prochlorperazine maleate 10mg/tab #30: 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: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines Functional Restoration Approach to Chronic Pain Management Page(s): 7.

Decision rationale: Finally, the request for prochlorperazine (Compazine), an antiemetic medication, was not medically necessary, medically appropriate, or indicated here. As noted on page 7 of the MTUS Chronic Pain Medical Treatment Guidelines, it is incumbent upon prescribing provider to incorporate some discussion of applicant specific variable such as other medications into his choice of pharmacotherapy. Here, the attending provider did not, however, concurrently prescribe two separate antiemetic medications, namely Compazine (prochlorperazine) with a second antiemetic medication Zofran (ondansetron). The MTUS Guideline in ACOEM Chapter 3, page 47, further stipulates that an attending provider incorporate some discussion of efficacy of medications for this particular condition for which it is being prescribed. Here, the attending provider did not ever outline whether or not ongoing usage of prochlorperazine (Compazine) had or had not been beneficial, nor did the attending provider outline how frequently the applicant was or not using prochlorperazine (Compazine). Therefore, the request was not medically necessary.