MAXIMUS Federal Services

Case Number:	CM15-0149254		
Date Assigned:	08/12/2015	Date of Injury:	04/24/2001
Decision Date:	09/14/2015	UR Denial Date:	07/22/2015
Priority:	Standard	Application Received:	07/31/2015

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: California, Texas, Florida
Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative 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 injured worker is a 50 year old male who sustained a work related injury April 24, 2001. According to the most recent office visit notes, dated March 24, 2015, the injured worker presented for follow-up with low back pain, rated 4 out of 10 with radiation to the right and left leg. His current medications are controlling his symptoms and pain, and improving his ability to exercise throughout the day. He also reports the medication improves his ability in dressing, eating and walking. Current medication included Tizanidine Hydrochloride, Oxycodone-Acetaminophen, Gabapentin, and Fentanyl. Examination of the lumbar spine revealed normal range of motion. His gait is antalgic. Diagnoses are lumbosacral disc degeneration; opioid dependence; chronic pain; lumbago; lumbosacral neuritis. A urine screen dated May 13, 2015, revealed consistent results. An x-ray of the left knee, performed May 14, 2015 revealed minimal degenerative changes. An x-ray of the right knee performed May 14, 2015 revealed minimal degenerative changes. At issue, is the request for authorization for Zolpidem Tartrate and Tizanidine Hydrochloride.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zolpidem Tartrate 5mg (quantity not specified): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain procedure summary-Zolpidem (Ambien) Mosby's drug consult.

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

Decision rationale: Regarding the request for zolpidem (Ambien), California MTUS guidelines are silent regarding the use of sedative hypnotic agents. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there are no subjective complaints of insomnia, no discussion regarding how frequently the insomnia complaints occur or how long they have been occurring, no statement indicating what behavioral treatments have been attempted for the condition of insomnia, and no statement indicating how the patient has responded to Ambien treatment. Finally, there is no indication that Ambien is being used for short term use as recommended by guidelines. In the absence of such documentation, the currently requested zolpidem (Ambien) is not medically necessary.

Tizanidine HCL 4mg (quantity not specified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66 of 127.

Decision rationale: Regarding the request for tizanidine, Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that tizanidine specifically is FDA approved for management of spasticity; unlabeled use for low back pain. Guidelines recommend LFT monitoring at baseline, 1, 3, and 6 months. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the tizanidine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Finally, it does not appear that there has been appropriate liver function testing, as recommended by guidelines. In the absence of such documentation, the currently requested tizanidine is not medically necessary.