

Case Number:	CM15-0027352		
Date Assigned:	02/19/2015	Date of Injury:	08/11/2009
Decision Date:	04/08/2015	UR Denial Date:	01/23/2015
Priority:	Standard	Application Received:	02/13/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 61-year-old male, who sustained an industrial injury on 8/11/09. He has complained of back and neck injury. The diagnoses have included chronic low back pain with radiculopathy and post laminectomy syndrome. Treatment to date has included medications, surgery, Transcutaneous Electrical Nerve Stimulation (TENS), psychological care, and functional restorative program. Surgery included lumbar laminectomy in 2010. Currently, the injured worker complains of low back pain that radiates to lower extremities left greater than right. He complains of anxiety and depression. He has been taking over the counter medications to help him sleep. He also reported an increase in muscle spasms as he was not able to get Zanaflex. He states that he gets significant relief of back pain with use of methadone. He is able to walk farther and perform activities of daily living (ADL's). Physical exam revealed spasm and guarding of the lumbar spine. Current medications were Tizanidine, Methadone, Ambien, Lorazepam, and combivent inhaler. Work status was permanent and stationary. On 1/23/15 Utilization Review non-certified a request for Tizanidine HCL 4mg #90 with 3 refills, Methadone HCL 10mg #100, and Ambien 10mg #30, noting that regarding Tizanidine HCL 4mg #90 with 3 refills, there has been sufficient time for weaning. Regarding the Methadone HCL 10mg #100, it was previous recommended for weaning; therefore continuing the weaning process is not warranted. Regarding the Ambien 10mg #30, previous recommended for weaning, therefore continuing the weaning process is not warranted. The (MTUS) Medical Treatment Utilization Schedule and (ACOEM) Occupational Medicine Practice Guidelines was cited. On 1/23/15 Utilization Review modified a request for Lorazepam 1mg #15 modified to 1

prescription of Lorazepam 1mg #5 between 1/14/15 and 3/21/15, noting that it was modified for weaning purposes. The Official Disability Guidelines (ODG) was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tizanidine HCL 4mg #90 with 3 refills: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants, ANTISPASTICITY/ANTISPASMODIC DRUGS, Medications for chronic pain Page(s): 63-66, 60.

Decision rationale: Based on the 01/14/15 progress report, the patient presents with low back pain with muscle spasms. The request is for TIZANIDINE HCL 4MG #90, 3 REFILLS. Patients diagnosis per RFA dated 03/26/14 includes chronic low back pain with radiculopathy, chronic neck pain, post laminectomy syndrome, deformities of brain and Sciatica. Per treater report dated 01/14/15, treater states, "patient is able to walk further distances, perform activities of daily living, function at a higher level with the use of his medications." Current medications include Tizanidine, Methadone, Ambien, Lorazepam, and combivent inhaler. Patient has been declared permanent and stationary. MTUS Chronic Pain Medical Treatment Guidelines for Muscle Relaxants for pain, pg 66:" ANTISPASTICITY/ANTISPASMODIC DRUGS: Tizanidine (Zanaflex, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. One study (conducted only in females) demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain." MTUS p60 also states, "A record of pain and function with the medication should be recorded," when medications are used for chronic pain. A prescription for Tizanidine was noted in progress reports dated 02/25/14, 09/02/14 and 01/29/15. Per treater report dated 01/14/15 treater states, "patient has not been able to get the zanaflex at last visit due to denial. He reports that he has an increase in his muscle spasms." Progress report dated 12/17/14, treater states, "Patient recalls an increase in his relaxation, decrease in his pain and an increase in ability to sleep with the use of Tizanidine. In this case, the implication is that Tizanidine was prescribed for treatment of muscle spasm. Therefore, given the patient's chronic pain and documented improvement with Tizanidine, the request IS medically necessary.

Methadone HCL 10mg #100: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Mehtadone (Dolophine, Methadose).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS, Medications for chronic pain Page(s): 60-61, 76-78, 88-89.

Decision rationale: Based on the 01/14/15 progress report, the patient presents with low back pain. The request is for METHADONE HCL 10MG #100, 3 REFILLS. Patients diagnosis per RFA dated 03/26/14 includes chronic low back pain with radiculopathy, chronic neck pain, post laminectomy syndrome, deformities of brain and Sciatica. Per treater report dated 01/14/15, treater states, "patient is able to walk further distances, perform activities of daily living, function at a higher level with the use of his medications." Current medications include Tizanidine, Methadone, Ambien, Lorazepam, and combivent inhaler. Patient has been declared permanent and stationary. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. MTUS p90 states, "Hydrocodone has a recommended maximum dose of 60mg/24hrs." A prescription for Methadone was noted in progress reports dated 02/25/14, 09/02/14 and 01/29/15. Per treater report dated 01/14/15 treater states, "The patient continues to find significant relief of his low back pain with the use of Methadone." However, MTUS guidelines require documentation of the 4As. There are no pain scales or validated instruments that address analgesia. The 4A's are not specifically addressed including discussions regarding adverse reactions, aberrant drug behavior, ADL's, etc. There are no discussions in relation to the UDS's, opioid pain agreement, or CURES reports, either. MTUS requires appropriate discussion of the 4A's. Given the lack of documentation as required by guidelines, the request IS NOT medically necessary.

Ambien 10mg #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; pain (chronic) Zolpidem (Ambien).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Pain (Chronic) Chapter, Zolpidem (Ambien).

Decision rationale: Based on the 01/14/15 progress report, the patient presents with low back pain. The request is for AMBIEN 10MG #30. Patients diagnosis per RFA dated 03/26/14 includes chronic low back pain with radiculopathy, chronic neck pain, post laminectomy syndrome, deformities of brain and Sciatica. Per treater report dated 01/14/15, treater states, "patient is able to walk further distances, perform activities of daily living, function at a higher level with the use of his medications." Current medications include Tizanidine, Methadone, Ambien, Lorazepam, and combivent inhaler. Patient has been declared permanent and stationary. ODG-TWC, Pain (Chronic) Chapter, Zolpidem (Ambien) Section states: "Zolpidem is a prescription short-acting nonbenzodiazepine hypnotic, which is recommended for short-term (7-10 days) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be

habit-forming, and they 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. (Feinberg, 2008)"A prescription for Ambien was noted in progress reports dated 02/25/14, 09/02/14 and 01/29/15. Per treater report dated 01/14/15 treater states, "Patient reports a history of sleep disturbances." ODG recommends Ambien for short-term (7-10 days) treatment of insomnia. Furthermore, the request for an additional quantity 30 does not indicate intended short-term use of this medication. The request is not in line with guideline indications. Therefore, the request IS NOT medically necessary.

Lorazepam 1mg #15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lorazepam (Benzodiamzepines). Decision based on Non-MTUS Citation Official Disability Guidelines; Lorazepam; Benzodiamzepines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines benzodiazepines Page(s): 24.

Decision rationale: Based on the 01/14/15 progress report, the patient presents with low back pain. The request is for LORAZEPAM 1MG #15. Patients diagnosis per RFA dated 03/26/14 includes chronic low back pain with radiculopathy, chronic neck pain, post laminectomy syndrome, deformities of brain and Sciatica. Per treater report dated 01/14/15, treater states, "patient is able to walk further distances, perform activities of daily living, function at a higher level with the use of his medications." Current medications include Tizanidine, Methadone, Ambien, Lorazepam, and combivent inhaler. Patient has been declared permanent and stationary. MTUS guidelines state on page 24 that benzodiazepines such as Xanax are "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks."A prescription for Lorazepam was noted in progress reports dated 02/25/14, 09/02/14 and 01/29/15. Patient has been prescribed this medication at least since 02/25/14, which is 11 months from UR date of 01/23/15. MTUS guidelines do not recommend use of Lorazepam for prolonged periods of time and state that most guidelines "limit use of this medication to 4 weeks." The request is not in accordance with guideline indications. Therefore, the request IS NOT medically necessary.