

Case Number:	CM15-0245571		
Date Assigned:	12/28/2015	Date of Injury:	06/23/2010
Decision Date:	01/29/2016	UR Denial Date:	11/24/2015
Priority:	Standard	Application Received:	12/17/2015

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: New York
 Certification(s)/Specialty: Internal 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 49 year-old female who sustained an industrial injury on 6-23-2010 and has been treated for Left L5 radiculopathy, L5-S1 spondylolisthesis, grade 1 and lateral recess stenosis, C5-C6 disc herniation and stenosis, bilateral plantar fasciitis, and failed low back surgery syndrome. The injured worker had a left L5 foraminotomy and L4-5 laminotomy on 9-2-2012. At a visit dated 11-13-2015, the injured worker presented with neck and low back pain radiating down the buttocks and the left lower extremity. On a pain scale where 10 is the most severe, the injured worker rated pain at 8 out of 10 with medication, and up to 10 out of 10 without medication. She reported continued sleep difficulties secondary to pain. Previous attempts of sleep hygiene or sleep study was not discussed in the note. The injured worker is totally, temporarily disabled. Significant objective findings included cervical spine and muscle tenderness with palpation, normal gait, and no lumbar tenderness noted with palpation. There was decreased sensation over the left L4-S1 dermatome distributions. Left-sided straight leg raise was positive at 80 degrees. Documented treatment has included "no physical therapy to date for the lumbar spine," cognitive behavioral therapy, biofeedback, a spinal cord stimulator, Xanax, Cymbalta, Norco, Trazadone, Cymbalta, and Zanaflex. A note dated 9 -8-2015 stated "discontinue Ambien" which was stated to be "no longer effective and she continues to have sleep difficulty." Urine toxicology screen dated 8-13-2015 showed no detection of Zolpidem. She was prescribed both Zolpidem and Tizanidine since at least 6-2015. The treating physician's plan of care included Ambien 10 mg #90 and Zanaflex 4 mg #90 which were both non-certified on 11-24-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10mg #90: 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 Chapter, Ambien.

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

Decision rationale: Ambien (Zolpidem) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term treatment of insomnia (usually two to six weeks) and is rarely recommended for long-term use. It can be habit-forming, and may impair function and memory more than opioid analgesics, and may increase pain and depression over the long-term. The treatment of insomnia should be based on the etiology and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. In this case, there was no documentation regarding a comprehensive work-up regarding potential sources of the patient's insomnia prior to prescribing a hypnotic, such as Zolpidem. There is no documentation provided indicating medical necessity for Ambien. The requested medication is not medically necessary.

Zanaflex 4mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: Zanaflex (Tizanidine) is a centrally acting alpha₂-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. It is indicated for the treatment of chronic myofascial pain and considered an adjunct treatment for fibromyalgia. According to CA MTUS Guidelines, muscle relaxants have not been considered any more effective than non-steroidal anti-inflammatory drugs (NSAIDs) for pain or overall improvement. There is no additional benefit shown in combination with NSAIDs. In addition, sedation is the most commonly reported adverse effect of muscle relaxant medications. The guideline criteria do not support the long-term use of muscle relaxants. Medical necessity for the requested medication has not been established. Zanaflex is not medically necessary.