

<b>Case Number:</b>	CM14-0120859		
<b>Date Assigned:</b>	10/09/2014	<b>Date of Injury:</b>	10/21/1998
<b>Decision Date:</b>	11/10/2014	<b>UR Denial Date:</b>	07/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/30/2014

### 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 Medicine and is licensed to practice in Texas and Ohio. 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 53 year old female who reported an injury on 10/21/1998. The mechanism of injury was not noted. Her diagnosis included cervical radiculopathy, cervicgia, chronic intractable pain, degenerative disc disease, depression and thoracic outlet syndrome. The previous treatments included medication. Diagnostic studies included a urine drug screen that was done on 04/07/2014. On 06/25/2014, the injured worker complained of neck and upper back pain. Upon examination, the injured worker had decreased range of motion of the neck, and myofascial tenderness to the cervical area. Her current medications included Ambien 10mg at bedtime, Lidoderm 5% topical 1 patch every 12 hours, and OxyContin 40mg 3 times a day. A request was received for 60 Tablets of Tizanidine 4 MG with 5 Refills, 30 Tablets of Ambien 10 MG with 5 Refills, and 60 Patches of Lidoderm 5 Percent with 5 Refills. The rationale for the requests was not clearly stated. The Request for Authorization form was submitted on 03/19/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**60 Tablets of Tizanidine 4 MG with 5 Refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASTICITY/ANTISPASMODIC DRUGS Page(s): 66.

**Decision rationale:** California MTUS guidelines state that Tizanidine is FDA approved for management of spasticity and in some cases low back pain. The injured worker complained of neck and upper back pain, and had decreased range of motion of the neck and myofascial tenderness to the cervical area. However, according to the documentation submitted the injured worker does not suffer from spasms. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

**30 Tablets of Ambien 10 MG with 5 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 (ODG), Pain chapter

**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 (Ambien).

**Decision rationale:** Official Disability Guidelines state that Ambien is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. The injured workers subjective complaints do not include insomnia. In addition, because the recommendation of Ambien is only for use two to six weeks, the request is for 5 refills is not warranted. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.

**60 Patches of Lidoderm 5 Percent with 5 Refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**Decision rationale:** MTUS guidelines states that lidocaine may be recommended for localized peripheral pain after a trial of first-line therapy. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. However, there is no evidence of a trial of first-line therapy. Therefore, the request is not medically necessary.