

Case Number:	CM15-0129161		
Date Assigned:	07/20/2015	Date of Injury:	12/04/2009
Decision Date:	08/24/2015	UR Denial Date:	06/11/2015
Priority:	Standard	Application Received:	07/02/2015

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: Florida
 Certification(s)/Specialty: Neurology, Pain Management

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 39 year old male patient who sustained an industrial injury on 12/04/2009. The injured worker noted being employed as a gas service representative tearing apart a regulator with a wrench and felt immediate pain in his right shoulder. He did undergo a course of physical therapy along with medications. The patient's first surgery was on 03/16/2012 and 04/10/2013. A recent primary treating office visit dated 06/01/2015 reported the patient with subjective complaint of having ongoing right shoulder pain and unchanged since the last visit. He continues to work full time regular work duty. Current medications are: Norco 10/325mg, Ambien, and Zanaflex. The patient is noted being status post right shoulder arthroscopy on 05/20/2014, and myofascial pain, right shoulder. A primary treating office visit dated 02/24/2014 reported chief complaints of having right shoulder pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ambien 10 mg Qty 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 (ODG) pain, zolpidem, sleep aid.

Decision rationale: The medical records provided for review indicate improvement in pain symptoms with report of sleep interference. ODG guidelines support short term use of sleep agent such as zolpidem or lunesta for 4 to 6 weeks when there is failure of 6 months of conservative care and sleep hygiene program. As the medical records provided for review do not indicate or document such failure, the medical records do not support a medical necessity for this treatment. The request is not medically necessary.

Zanaflex 4 mg Qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine (Zanaflex), non-sedating muscle relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines zanaflex Page(s): 66.

Decision rationale: The medical records provided for review do not demonstrated physical exam findings consistent with spasticity or muscle spasm or myofascial spasm. MTUS supports zanaflex for the treatment of muscle spasm and spasticity. As such the medical records do not support the use of zanaflex congruent with MTUS. The request is not medically necessary.

Ambien 10 mg Qty 30 (do not dispense until 7/1/15): 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 (ODG) pain, zolpidem, sleep aid.

Decision rationale: The medical records provided for review indicate improvement in pain symptoms with report of sleep interference. ODG guidelines support short term use of sleep agent such as zolpidem or lunesta for 4 to 6 weeks when there is failure of 6 months of conservative care and sleep hygiene program. As the medical records provided for review do not indicate or document such failure, the medical records do not support a medical necessity for this treatment. The request is not medically necessary.

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