

Case Number:	CM15-0171059		
Date Assigned:	09/11/2015	Date of Injury:	03/11/2004
Decision Date:	10/15/2015	UR Denial Date:	07/28/2015
Priority:	Standard	Application Received:	08/31/2015

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, Hawaii
 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 34 year old female who sustained an industrial injury on 03-11-2004. Current diagnoses include displacement lumbar intervertebral disc without myelopathy, predominant disturbance of emotions, thoracic-lumbosacral neuritis-radiculitis, and depressive disorder. Report dated 07-16-2015 noted that the injured worker presented with complaints that included the neck and upper back. Pain level was 7 out of 10 on a visual analog scale (VAS). Physical examination was positive for tenderness to palpation of the lumbar, sacral, midline, and sacroiliac joint areas, positive muscle spasm, decreased lower extremity strength, sensation, and range of motion, and positive straight leg raise. Previous diagnostic studies included MRI's and EMG-NCV study. Previous treatments included medications, psychiatric-psychological evaluation, bariatric surgery, and epidural injection. The treatment plan included referrals for pain management, back specialist, aqua therapy, ordered a urine drug screening, reviewed past medical records, refilled medications which included Norco, gabapentin, ranitidine, estazolam, and tizanidine, and return in 6 weeks. The injured worker was to remain off work until 08-27-2015. The injured worker has been prescribed tizanidine and estazolam since at least 01-14-2015. The utilization review dated 07-28-2015, modified the request for 30 tablets of tizanidine to 15 tablets of tizanidine, and 30 tablets of estazolam to 15 tablets of estazolam based on the following rational. "The guidelines only recommend these medications for short-term use. Further clarification is needed regarding exactly how long the patient has been prescribed these medications. Also, there is lack of documentation showing their efficacy, such as a quantitative decrease in pain or an objective improvement in function."

IMR ISSUES, DECISIONS AND RATIONALES

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

Tizanidine 4mg #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

Decision rationale: The patient presents with diagnoses include displacement lumbar intervertebral disc without myelopathy, predominant disturbance of emotions, thoracic-lumbosacral neuritis-radiculitis, and depressive disorder. The patient currently complains of neck and upper back pain. The patient is total temporarily disabled. The current request is for Tizanidine 4mg #30. Tizanidine is a muscle relaxant. The treating physician states in the treating report dated 7/16/15 (26b), Refilled Tizanidine, 4 mg 1 tablet orally qhs. #30 tablets. No refills. MTUS guidelines state that, Tizanidine (Zanaflex) is a centrally acting alpha-2 adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. The MTUS guidelines support the usage of Tizanidine for chronic low back pain, myofascial pain and fibromyalgia. In this case, the clinical history notes that patient has chronic lower back pain that is successfully medicated with Tizanidine since at least 4/23/15 (112b). The current request is medically necessary.

Estazolam 2mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Benzodiazepines.

Decision rationale: The patient presents with diagnoses include displacement lumbar intervertebral disc without myelopathy, predominant disturbance of emotions, thoracic-lumbosacral neuritis-radiculitis, and depressive disorder. The patient currently complains of neck and upper back pain. The patient is total temporarily disabled. The current request is for Estazolam 2mg #30. The treating physician states in the treating report dated 7/16/15 (26b), refilled Estazolam 2 Mg Tablet 1 tablet orally once a day, #30 tablets. No Refills. MTUS guidelines page 24 states, benzodiazepines are not recommended for long-term use because long-term efficacies are unproven and there is a risk of dependence. Benzodiazepines run the risk of dependence and difficulty of weaning per MTUS and ODG Guidelines. It is not recommended for a long-term use. Most guidelines limit use to 4 weeks. In this case, the clinical history documents that the patient has been medicated with Estazolam for an unspecified amount of time but usage appears to date back since at least 4/23/15 (112b). The current request is not medically necessary.