

<b>Case Number:</b>	CM15-0075729		
<b>Date Assigned:</b>	05/29/2015	<b>Date of Injury:</b>	12/29/2008
<b>Decision Date:</b>	07/22/2015	<b>UR Denial Date:</b>	04/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/20/2015

### 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: Arizona, California  
Certification(s)/Specialty: Family Practice

### 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 51 year old female, who sustained an industrial injury on 12/29/2008. Diagnoses include knee/lower leg degenerative joint disease, arthritis, major depressive disorder single episode and other pain disorder related to psychological factors. Treatment to date has included medications and physical therapy. Per the Primary Treating Physician's Progress Report dated 3/18/2015, the injured worker reported progressive symptoms in her bilateral knees. She rates her pain as characteristically 3/10. Physical examination revealed marked instability with tenderness and a limping ambulation. X-rays of the bilateral knees showed no increase in osteoarthritis. The plan of care included medication management and authorization was requested for Ambien 10mg, Oxycodone 15mg, Tizanidine 4mg, Gabapentin 800mg, Gabapentin 600mg and Cymbalta 60mg.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) prescription of 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 (ODG), Insomnia.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG), Insomnia, page 64.

**Decision rationale:** The MTUS guidelines do not comment on insomnia. According to the ODG guidelines, insomnia medications recommend that treatment be based on the etiology, with the medications. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. Zolpidem is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). In this case, the claimant had used the medication for several months. The etiology of sleep disturbance was not defined or further evaluated. Pain was likely causing sleep disturbance rather than a primary sleep disorder. Continued use of Zolpidem is not medically necessary.

**One (1) prescription of Oxycodone 15mg #165:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 82-92.

**Decision rationale:** Oxycodone is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated as 1st line therapy for neuropathic pain, and chronic back pain . It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. In this case, the claimant had been on Oxycodone for several months and recently required an increase in use of medications. Failure of Tylenol, NSAID or Tricyclic was not noted. Long-term use has not been studied and continued use is not medically necessary.

**One (1) prescription of Tizanidine 4mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63.

**Decision rationale:** According to the MTUS guidelines, Zanaflex (Tizanidine) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. Eight studies have demonstrated efficacy for low back pain. It falls under the category of muscle relaxants. According to the MTUS guidelines, muscle relaxants are to be used with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most low back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. In this case, the claimant had been on Tizanidine for several months in combination with Oxycodone. The pain

level had been increasing. Continued and chronic use of muscle relaxants /antispasmodics is not medically necessary. Therefore Tizanidine is not medically necessary.