

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 11/21/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/31/2013
Date of Injury:	2/23/2000
IMR Application Received:	8/6/2013
MAXIMUS Case Number:	CM13-0008272

- 1) MAXIMUS Federal Services, Inc. has determined the request for Tizanidine 2mg #90 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Zolpidem 10mg #30 **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/6/2013 disputing the Utilization Review Denial dated 7/31/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/11/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for Tizanidine 2mg #90 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Zolpidem 10mg #30 **is not medically necessary and appropriate.**

### **Medical Qualifications of the Expert Reviewer:**

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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 treatments and/or services at issue.

### **Expert Reviewer Case Summary:**

The patient is a 48-year-old male who reported an injury to his low back on 02/23/2000. He landed on the floor trying to help a patient. The patient is noted to have a surgical history of a lumbar laminectomy in 2001 and lumbar fusions in 2005, 2006, and 2008. A CT of the lumbar spine performed on 03/16/2011 without contrast, read by Dr. [REDACTED] reported a conclusion of no disc herniation status post instrumented fusion at L4-5 with interbody disc spacer, and decompressive laminectomy, and the neural foramina and canal were capacious. A clinical note dated 07/09/2013 reported the patient complained of low back pain with radiation of pain to the bilateral lower extremities. He also complained of bilateral lower extremity pain, bilateral hip pain, bilateral foot pain, bilateral knee pain, bilateral groin pain, and bilateral ankle pain. He was noted to have undergone multiple surgeries to the lumbar spine and to be currently taking Ambien 6.25 mg, Celebrex 200 mg, using a fentanyl patch 50 mg, Lyrica 100 mg, Norco 10 mg every 6 hours, Flomax, and Cymbalta. The patient is noted to complain of constant low back pain radiating to the bilateral hips and buttocks, and pain to the bilateral lower extremities. He also reported numbness and tingling in the lower extremities and weakness of the left lower extremity. He rated his pain 6/10, which was aggravated by standing, walking, sitting, bending, twisting, turning, and rotation. He reported severe difficulty in sleep. On physical examination, the patient is noted to have spasms of the bilateral paraspinal muscles from L2-S1 levels, spinal vertebral tenderness bilaterally from the L2-S1 level, range of motion of the lumbar spine was limited secondary to pain and pain was significantly increased with flexion, extension, and bending. The patient is noted to have 6 degrees of flexion, 10 degrees of extension, and 30 degrees of left and right side bending. On motor exam, the patient had decreased strength of the flexor and extensor muscles of the bilateral lower extremities, straight leg raise in seated position was positive in the bilateral extremities for radicular pain at 40 degrees. An MRI

reported to have been performed in 03/2011 reported no retro or anterolisthesis and was reported to have no abnormal findings. A Letter of Determination from [REDACTED] dated 07/31/2013 non-certified the request for tizanidine and zolpidem, noting that the request for tizanidine did not meet guideline recommendations, as the chronic pain treatment guidelines did not recommend long-term use of muscle relaxants and although muscle spasms were documented on physical examination, there was no specific documented functional improvement with any previous use of this medication for the patient. The request for zolpidem was non-certified, as the guidelines do not recommend long-term use of sleep aids. There were documented current sleep disturbances. However, there was no evidence of sleep behavioral modification attempts or documentation of failed trials of other guideline-supported treatment. As such, the request was non-certified. A clinical note dated 08/06/2013 reported the patient continued to complain of low back pain radiating to the bilateral lower extremities, which he rated 6/10 to 7/10 with medications and 9/10 to 10/10 without medications. The patient is reported to have functional limitations in ambulation, sleep, and sex. On physical examination, the patient is noted to have an antalgic gait, moderate reduction of range of motion of the lumbar spine secondary to pain, significantly increased pain with flexion and extension, paraspinal vertebral tenderness at the lumbar spine at the L4-S1 levels, lumbar myofascial tenderness on palpation, no changes on sensory or motor exam.

#### **Documents Reviewed for Determination:**

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

#### **1) Regarding the request for Tizanidine 2mg #90:**

##### Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, pg. 66, which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Muscle Relaxants, pg. 63, 66, which is a part of the MTUS.

##### Rationale for the Decision:

After a review of the medical records provided for review, the employee reported an injury to the low back on 02/23/2000. The employee is noted to have undergone a lumbar laminectomy in 2001 and to have undergone lumbar fusions in 2005, 2006, and 2008. Also noted are complaints of ongoing low back pain with radiation of pain into the bilateral lower extremities with numbness and tingling, which was rated 6/10 to 7/10 with medications and 9/10 to 10/10 without

medications. The employee was noted on physical examination to have limited range of motion of the low back with pain and significantly increased pain on flexion and extension. Also reported is decreased strength in the flexor and extensor muscles of the bilateral lower extremities and positive straight leg raise of the bilateral lower extremities for radicular pain at 40 degrees. The employee was noted to have muscle spasms on palpation in the lumbar spine. The employee is noted to have been taking tizanidine for muscle spasms. The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations for patients with chronic low back pain. It states that tizanidine is FDA approved for management of spasticity, but is used offlabel for low back pain. Although the employee is noted to have spasms and ongoing chronic low back pain, it appears that the employee is utilizing the tizanidine on a routine ongoing basis and not for exacerbation of low back pain or treatment of occasional spasms. As such, the requested tizanidine does not meet guideline recommendations. Based on the above, **the request for tizanidine 10 mg #90 is not medically necessary and appropriate.**

**2) Regarding the request for Zolpidem 10mg #30:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines (ODG)-Treatment in Workers Comp 2012 on the Web. Wrok Loss Data Institute, which is not a part of the MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on Official Disability Guidelines (ODG), Online version, Pain (Chronic) Chapter, Zolpidem, which is not a part of the MTUS.

Rationale for the Decision:

After a review of the medical records provided for review the employee reports severe difficulty in sleeping. California MTUS Guidelines do not address the requested Ambien. The Official Disability Guidelines recommend Ambien for short-term, usually 2 to 6 weeks, treatment of insomnia. It appears that the patient has been taking the Ambien on a long-term routine basis for treatment of insomnia without any documentation of improvement of sleep complaints with its use. The requested zolpidem does not meet guideline recommendations. **The request for Zolpidem 10 mg #30 is not medically necessary and appropriate.**

**Effect of the Decision:**

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.