

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Notice of Independent Medical Review Determination

Dated: 11/27/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/31/2013
Date of Injury: 7/11/2010
IMR Application Received: 8/7/2013
MAXIMUS Case Number: CM13-0007673

- 1) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Tizanidine HCL 4mg #30 for DOS 5/8/2013 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Nucynta 75mg #90 for DOS 5/9/2013 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Zolpidem Tartrate 10mg #30 for DOS 5/8/2013 is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/7/2013 disputing the Utilization Review Denial dated 7/31/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/6/2013. 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 retrospective request for **Tizanidine HCL 4mg #30 for DOS 5/8/2013 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Nucynta 75mg #90 for DOS 5/9/2013 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request for **Zolpidem Tartrate 10mg #30 for DOS 5/8/2013 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 54-year-old female with a date of injury 11/10/2007. The patient states she sustained an orthopedic injury to her neck and left shoulder after passing out while standing in a dispatch room where she works. She fell onto her left side and struck and injured her left shoulder on the counter. She had immediate neck and left shoulder discomfort. The patient was diagnosed with left shoulder impingement syndrome. She was provided with physical therapy and 1 cortisone injection. Arthroscopic surgery to the left shoulder was performed on 09/13/2011 by Dr. [REDACTED]. In 06/2012, she received right shoulder cortisone injection and immediately thereafter developed severe right shoulder pain with loss of range of motion and increasing pain down the entire right side of her body into the buttock and hip. The patient reports her pain has been excruciating despite high doses of Norco and Percocet. Currently, the patient rates her right shoulder pain as 10/10. In addition, she has 9/10 neck pain and moderate tenderness over the right upper buttock and hip with right leg radiating symptoms of numbness and tingling secondary to lumbar spine pain. The patient indicates that her neck pain increases with activity and is partially relieved by taking pain medication. She had right pain to the right supraclavicular area that radiated into her shoulder blade down into the right hand and is associated with weakness and numbness of the right hand. The patient was only able to raise the right arm 90 degrees. Pain was reported as 8/10 and constant. In addition, the pain radiated into the right side of her head causing

headaches in addition to swelling of the right side of her face. Her treatment has consisted of various different medications, physical therapy, H-wave treatment and injections.

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 retrospective request for Tizanidine HCL 4mg #30 for DOS 5/8/2013:

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, Tizanidine, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Antispasticity/Antispasmodic Drugs, pg. 66, which is part of the MTUS.

Rationale for the Decision:

Chronic Pain Medical Treatment Guidelines indicate that tizanidine is a centrally acting alpha 2 adrenergic agonist that is FDA approved for management of spasticity as well as unlabeled use for low back pain. In addition, the guidelines indicate that use of muscle relaxants such as tizanidine are to be used with caution as a second line option for short-term less than 2 weeks treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with low back pain. The records provided for review do indicate the employee has a longstanding history of back pain. Furthermore, medical records indicate the use of tizanidine in the treatment of low back pain as well as muscle spasms with some reported relief. However, the use of such medications is only indicated for short-term use of either acute low back pain or acute exacerbations in patients with chronic low back pain. According to the records submitted for review, this medication is no longer being used on an acute basis. Therefore, the continued use of this medication can no longer be supported and is not medically necessary. **The retrospective request for Tizanidine HCL 4mg #30 for DOS 5/8/2013 is not medically necessary and appropriate.**

2) Regarding the retrospective request for Nucynta 75mg #90 for DOS 5/9/2013:

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, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opioids, pg. 74, which is part of the MTUS.

Rationale for the Decision:

While Nucynta is not specifically recognized by the California MTUS, it is an opioid agonist and, therefore, its use follows the MTUS guideline recommendations for the use of opioids. Nucynta is efficacious and provides efficacy that is similar to oxycodone for the management of chronic osteoarthritis of the knee and low back pain with a superior gastrointestinal tolerability profile and fewer treatment discontinuations. Tapentadol has an immediate-release formula that has been approved for moderate to severe acute pain. In addition, an extended release formulation for moderate to severe chronic pain has been approved by the FDA as well. The documentation submitted for review does indicate the employee suffers from chronic pain with diagnoses of chronic pain syndrome and CRPS being considered. The employee was started on Nucynta 100 mg by mouth 4 times a day on 08/22/2012. Guidelines indicate that a patient should have documentation of a failed trial of non-opioid analgesics. There should also be baseline pain and functional assessments made. Function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale. Pain related assessment should include history of pain treatment and effective pain and function. While the documentation submitted for review does indicate the employee suffers from chronic pain, there is no clear documentation of a failed trial of non-opioid analgesics. Furthermore, treatment guidelines indicate that the continued use of opioids in the treatment of chronic pain require an ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessments should include current pain, the least reported pain over the period since last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. After reviewing the documentation submitted for this employee, it appears as though there is a lack of evidence to support the long-term necessity of Nucynta. There was no documentation submitted concerning ongoing review and documentation of the employee's pain relief and functional status etc. Guidelines cannot support ongoing use of an opioid without documentation of its efficacy. **The retrospective request for Nucynta 75mg #90 for DOS 5/9/2013 is not medically necessary and appropriate.**

3) Regarding the retrospective request for Zolpidem Tartrate 10mg #30 for DOS 5/8/2013:

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), which is not 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 the Official Disability Guidelines (ODG), Pain Chapter.

Rationale for the Decision:

Zolpidem tartrate 10 mg is not medically indicated. Official Disability Guidelines indicate that zolpidem is a prescription short acting non-benzodiazepine hypnotic which is approved for the short-term usually 2 to 6 weeks treatment of insomnia. Poor sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. According to the documentation submitted for review, this employee does not have a diagnosis of insomnia. Furthermore, there is no documentation of any poor sleep hygiene habits. As such, the rationale behind this request is unclear. Furthermore, this medication is used only in short-term treatment of insomnia. The records indicate this employee has been using Zolpidem on a more chronic basis. As such, guidelines cannot support the use of Zolpidem in a patient who does not have diagnosis of insomnia or a clear rationale as to why this medication might be prescribed. **The retrospective request for Zolpidem Tartrate 10mg #30 for DOS 5/8/2013 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, 18th Floor
Oakland, CA 94612

/ldh

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.