

<b>Case Number:</b>	CM13-0046789		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	06/01/1999
<b>Decision Date:</b>	02/21/2014	<b>UR Denial Date:</b>	10/29/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/04/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Emergency Medicine and is licensed to practice in New York and Tennessee. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 50-year-old female with complaints of continuing neck and low back pain. Date of injury was June 1, 1999. Diagnoses included S/P cervical fusion x 2 at C5-6 and C6-7, S/P lumbar fusion at L1-2, L4-5, S/P instrumented fusion L1-L5, and right shoulder impingement. Treatment included medications, TENS unit, and trigger point injections. Requests for authorization for Prilosec 20 mg # 60, Flexeril 10 mg # 60, Flexeril 5 mg, and Ambien 10 mg were submitted on October 22, 2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Prilosec 20mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs and GI distress..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 68.

**Decision rationale:** Prilosec is a proton pump inhibitor (PPI). PPI's are used in the treatment of peptic ulcer disease and may be prescribed in patients who are using non-steroidal anti-inflammatory drugs and are at high risk for gastrointestinal events. Risk factors for high-risk events are age greater than 65, history of peptic ulcer, GI bleeding or perforation, concurrent use

of ASA, corticosteroids, and/or an anticoagulant, or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The patient in this case was using selective COX 2 NSAID Celebrex but did not have any of the risk factors for a gastrointestinal event. She had reported gastric distress in the past with other NSAIDS, but there was no documentation of gastric distress for many months. Medical necessity for Prilosec 20 mg bid is not established.

**Flexeril 10mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril)..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 63-64.

**Decision rationale:** Flexeril is the muscle relaxant Cyclobenzaprine. Non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP 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. Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. Drugs with the most limited published evidence in terms of clinical effectiveness include chlorzoxazone, methocarbamol, dantrolene and baclofen. According to a recent review in [REDACTED], skeletal muscle relaxants are the most widely prescribed drug class for musculoskeletal conditions (18.5% of prescriptions), and the most commonly prescribed antispasmodic agents are carisoprodol, Cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine is recommended as an option, for a short course of therapy. It has been found to be more effective than placebo with greater adverse side effects. Its greatest effect is in the first 4 days. Treatment should be brief. In this case the flexeril was being prescribed as a long-term medication.

**Flexeril 5mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril)..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 63-64.

**Decision rationale:** Flexeril is the muscle relaxant Cyclobenzaprine. Non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP 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. Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. Drugs with the most limited published evidence in terms of clinical effectiveness include chlorzoxazone, methocarbamol, dantrolene and baclofen. According to a recent review in American Family Physician, skeletal muscle relaxants are the most widely prescribed drug class for musculoskeletal conditions (18.5% of prescriptions), and the most commonly prescribed antispasmodic agents are carisoprodol, Cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine is recommended as an option, for a short course of therapy. It has been found to be more effective than placebo with greater adverse side effects. Its greatest effect is in the first 4 days. Treatment should be brief. In this case the flexeril was being prescribed as a long-term medication.

**Ambien 10mg:** 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) Pain, Zolpidem.

**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.

**Decision rationale:** Ambien is the medication Zolpidem. Zolpidem is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. While sleeping pills, so-called minor tranquilizers, and anti-anxiety agents are commonly prescribed in chronic pain, pain specialists rarely, if ever, recommend them for long-term use. They can be habit-forming, and they may impair function and memory more than opioid pain relievers. There is also concern that they may increase pain and depression over the long-term. Cognitive behavioral therapy (CBT) should be an important part of an insomnia treatment plan. A study of patients with persistent insomnia found that the addition of zolpidem immediate release to CBT was modestly beneficial during acute (first 6 weeks) therapy, but better long-term outcomes were achieved when zolpidem IR was discontinued and maintenance CBT continued. (Due to adverse effects, FDA now requires lower doses for zolpidem. The dose of zolpidem for women should be lowered from 10 mg to 5 mg for IR products (Ambien, Edluar, Zolpimist, and generic) and from 12.5 mg to 6.25 mg for ER products (Ambien CR). The ER product is still more risky than IR. In laboratory studies, 15% of women and 3% of men who took a 10-milligram dose of Ambien had potentially dangerous concentrations of the drug in their blood eight hours later. Among those who took Ambien CR, the problem was more common: 33% of women and 25% of men had blood concentrations that would raise the risk of a motor vehicle accident eight hours later. Even at the lower dose of Ambien CR now recommended by the FDA, 15% of women and 5% of men still had high levels of the drug in their system in the morning. According to SAMHSA,

zolpidem is linked to a sharp increase in ED visits, so it should be used safely for only a short period of time.