

<b>Case Number:</b>	CM14-0195513		
<b>Date Assigned:</b>	12/03/2014	<b>Date of Injury:</b>	03/14/2014
<b>Decision Date:</b>	01/15/2015	<b>UR Denial Date:</b>	11/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/21/2014

### 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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in New York. 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/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 52 year old female food service cafeteria worker with a date of injury of 03/14/2014. She had a lumbar and knee injury. On 03/17/2014 she returned to work and worked for the entire week. On 03/26/2014 she was given work restrictions. Starting in 04/2014 she had at least 16 physical therapy visits and was also treated with acupuncture. She was treated with acupuncture, physical therapy, activity modification, medications and physical therapy. She last worked on 08/28/2014. On 10/10/2014 her low back pain was 6/10. Left leg pain was 7/10. She was taking Dexilent (muscle relaxant). Orphenadrine was ordered. On 11/04/2014 she had low back pain radiating to both lower extremities. She had lumbar paravertebral muscle spasm. The knee range of motion was normal for both knees. There was joint line tenderness. McMurray's sign was positive for both knees. Chiropractic care was ordered. Zolpidem was ordered and Orphenadrine was renewed. On 12/03/2014 she had low back pain and knee pain. Massage therapy and acupuncture were ordered. Zolpidem and Cyclobenzaprine were ordered.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Zolpidem tartrate 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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Zolpidem FDA approved package insert

**Decision rationale:** First, there is no documentation that long term use (greater than 35 days) of Zolpidem is safe and effective treatment. Second, the FDA recently noted that, for women, the dose of Zolpidem of 10 mg is not safe since that dose in women is associated with increased blood levels of the medication. So for women only the 5 mg dose is FDA approved as safe and effective. Therefore the request is not medically necessary.

**Orphenadrine ER 100mg #60 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

**Decision rationale:** CHRONIC PAIN MEDICAL TREATMENT GUIDELINES Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 63. Muscle relaxants (for pain) Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) 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. (Homik, 2004) 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. (Chou, 2004) 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. Long term use of muscle relaxants is not consistent with MTUS guidelines.