

<b>Case Number:</b>	CM15-0083309		
<b>Date Assigned:</b>	05/05/2015	<b>Date of Injury:</b>	10/27/2001
<b>Decision Date:</b>	06/24/2015	<b>UR Denial Date:</b>	04/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/30/2015

### 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: New York  
 Certification(s)/Specialty: Anesthesiology

### 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 63 year old female, who sustained an industrial injury on 10/27/2001. The mechanism of injury is unknown. The injured worker was diagnosed as having internal disc disruption with torn annular fibers, moderate central canal stenosis with 5 medication management disc herniation, suspect left sacroilitis, and sacroiliac joint dysfunction. There is no record of a recent diagnostic study. Treatment to date has included lumbosacral blocks, radiofrequency neurolysis of the lumbosacral spine, lumbar epidural steroid injection and medication management. In a progress note dated 3/31/2015, the injured worker complains of low back stiffness and pain-rated 8/10. The treating physician is requesting Amitriptyline 50 mg #60-3 refills, Neurontin 600 mg #150-3 refills, Flexeril 10 mg #60-3 refills, Prilosec 20 mg #30-3 refills, Xanax 0.5 mg #90 and Tizanidine 2 mg #90-3 refills.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Amitriptyline 50 mg Qty 60 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Amitriptyline; Antidepressants for chronic pain Page(s): 13.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Antidepressants for chronic pain.

**Decision rationale:** According to the ODG, tricyclic antidepressants, such as Amitriptyline (Elavil) are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclic antidepressants are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effect takes longer to occur. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Side effects, including excessive sedation (especially that which would affect work performance) should be assessed. The optimal duration of treatment is not known because most double-blind trials have been of short duration (6-12 weeks). It has been suggested that if pain is in remission for 3-6 months, a gradual tapering of anti-depressants may be undertaken. In this case, previous determinations recommended weaning of this medication due to a lack of improvement noted with long-term use. Medical necessity for the requested medication has not been established. The medication is not medically necessary.

**Neurontin 600 mg Qty 150 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 16-18.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 17-19.

**Decision rationale:** Neurontin (Gabapentin) is an anti-epilepsy drug which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. Previous determinations commenced and completed the weaning process for this medication. There is no documentation of objective findings consistent with current neuropathic pain to necessitate use of Neurontin. Medical necessity for Neurontin has not been established. The requested medication is not medically necessary.

**Flexeril 10 mg Qty 60 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-65.

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

**Decision rationale:** According to the reviewed literature, Cyclobenzaprine (Flexeril) is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. In addition, this medication is not recommended to be used

for longer than 2-3 weeks. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. In this case, the patient is complaining of muscle spasms and given there does not appear to be any previous use of muscle relaxant therapy proceeding with a trial is warranted. However, the request is for 60 pills with 3 refills. There is no indication for long-term treatment with muscle relaxant therapy. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested medication is not medically necessary.

**Prilosec 20 mg Qty 30 with 3 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain (chronic) - Proton Pump Inhibitors (PPIs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PPIs Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

**Decision rationale:** According to CA MTUS (2009), proton pump inhibitors, such as Omeprazole (Prilosec), are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. There is no documentation indicating the patient has any GI symptoms or GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. There is no documentation of any reported GI complaints. Based on the available information provided for review, the medical necessity for Prilosec has not been established. The requested medication is not medically necessary.

**Xanax 0.5 mg Qty 90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** Alprazolam (Xanax) is a short-acting benzodiazepine drug having anxiolytic, sedative, and hypnotic properties. The medication is used in conjunction with antidepressants for the treatment of depression with anxiety, and panic attacks. Per California MTUS Guidelines, benzodiazepines are not recommended for long-term use for the treatment of chronic pain because long-term efficacy is unproven and there is a risk of dependency. Most guidelines limit use to four weeks. Medical necessity of the requested medication has not been established. The requested medication is not medically necessary.

**Tizanidine 2 mg Qty 90 with 3 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-65.

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

**Decision rationale:** Zanaflex (Tizanidine) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. It is indicated for the treatment of chronic myofascial pain and considered an adjunct treatment for fibromyalgia. According to the CA MTUS Guidelines, muscle relaxants have not been considered any more effective than non-steroidal anti-inflammatory drugs (NSAIDs) for pain or overall improvement. In addition, sedation is the most commonly reported adverse effect of muscle relaxant medications. In this case, the patient has reported muscle spasm with LBP rated 8/10. The guideline criteria do not support the long-term (>2 wks) use of muscle relaxants. Based on these guideline criteria, medical necessity for the requested Tizanidine, with 3 refills, has not been established. The requested medication is not medically necessary.