

<b>Case Number:</b>	CM13-0032299		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	08/11/2002
<b>Decision Date:</b>	05/19/2014	<b>UR Denial Date:</b>	09/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/18/2013

### 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 Orthopedic Surgery and is licensed to practice in Arizona. 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 51-year-old female who sustained an injury to her back on 8/11/2002. She is complaining of chronic low back pain with radiation to both legs associated with numbness and tingling down to her feet. Her back pain is greater than her leg pain. An examination on September 10, 2013 revealed decreased lumbar spinal motion with tenderness to palpation. There is no motor or sensory deficit and the straight leg raise is negative. Imaging reveals L4-L5 disc desiccation, with right paraspinal protrusion and lateral recess stenosis. There is L5-S1 disc bulge and foraminal stenosis. The note on March 6, 2013, states that the patient has been treated with epidural injections in the past and generally they have achieved approximately 60% relief from pain. She was able to reduce her medication during these periods and allowed her to tolerate her physical activities, involvement with daily living and with her occupation to a much better degree. Without medication the pain is rated 10/10, and with medication it is rated 4-5/10. The request is made for Norco 7.5/325 mg, six (6) a day for pain and for Amrix 15 mg one (1) daily.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PRESCRIPTION OF HYDROCODONE 7.5/325MG #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 74-96.

**Decision rationale:** This prescription is for ongoing pain management. The September 10th report indicates that the patient did cut down her dosage for a while. The Chronic Pain Guidelines indicate that a satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. There is no ongoing documentation to this effect. There is no documentation of the 4 A's for ongoing monitoring. This would include pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behavior. In addition, in the note of March 6, 2013, it is mentioned that the patient cut down her dose of Norco, which was filled on December of 2012, until she was able to establish a new treating physician. There is no indication that she had any significant change in her pain level. Therefore, for the above reasons, the medical necessity for the Norco prescription 7.5/325 # 180 has not been established.

**PRESCRIPTION OF AMRIX 15MG #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS (FOR PAIN) Page(s): 63. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, MUSCLE RELAXANTS

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CYCLOBENZAPRINE Page(s): 41-42.

**Decision rationale:** The Chronic Pain Guidelines recommend a short course of therapy where effect is greatest in the first four (4) days of treatment and the treatment should be brief. The addition of cyclobenzaprine to other agents is not recommended. The patient has been on this medication for at least 2-1/2 years. Therefore, according to guidelines, the medical necessity for the continuing use of Amrix has not been established.