

<b>Case Number:</b>	CM13-0043509		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	07/13/2000
<b>Decision Date:</b>	04/18/2014	<b>UR Denial Date:</b>	10/17/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/23/2013

### 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 [REDACTED], has a subspecialty in Pain Management 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 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:

According to the records made available for review, this is a 49-year-old male with a 7/13/00 date of injury. At the time (10/1/13) of request for authorization for Norco 5mg #120, Norco 10mg #120, Flexeril 10mg #120, Ambien 10mg #30, there is documentation of subjective low back pain that is about 7/10 to 8/10, coming down to 4/10 to 5/10 with medications; and that there are some days with severe muscle spasms. Objective findings include tenderness over the iliac crest and some pain with extension of the lumbar spine. Current diagnoses are chronic left sided low back pain. Treatment to date include lumbar spine medial branch block, radiofrequency ablation, and medications (including Norco 5/325, Norco 10/325, Flexeril, and Ambien since at least 8/29/12)). Medical report identifies a consistent urine drug screen from 7/10/13.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**NORCO 5MG #120,:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Ongoing Management Page(s): 74-82.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of a diagnosis of chronic left sided low back pain. In addition, there is documentation of ongoing treatment with Norco 5/3255 since at least 8/29/12. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, despite documentation of low back pain that is about 7/10 to 8/10, coming down to 4/10 to 5/10 with medications, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Norco use to date. The request for Norco 5mg #120 is not medically necessary and appropriate

**NORCO 10MG #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Ongoing Management Page(s): 74-82.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of a diagnosis of chronic left sided low back pain. In addition, there is documentation of ongoing treatment with Norco 10/3255 since at least 8/29/12. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, despite documentation of low back pain that is about 7/10 to 8/10, coming down to 4/10 to 5/10 with medications, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Norco use to date. The request for Norco 10mg #120 is not medically necessary and appropriate.

**FLEXERIL 10MG #120: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 63-64. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain).

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines identifies that Flexeril is recommended for a short course of therapy. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. The Official Disability Guidelines (ODG) identifies that muscle relaxants are recommended as a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Within the medical information available for review, there is documentation of a diagnosis of chronic left sided low back pain. In addition, there is documentation of ongoing treatment with Flexeril since at least 8/29/12. However, despite documentation of subjective findings (some days with severe muscle spasms), and given documentation of a 7/13/00 date of injury, there is no documentation of acute muscle spasm. In addition, given documentation of records reflecting prescriptions for Flexeril since at least 8/29/12, there is no documentation of the intention to treat over a short course (less than two weeks). Furthermore, despite documentation of low back pain that is about 7/10 to 8/10, coming down to 4/10 to 5/10 with medications, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Flexeril use to date. The request for Flexeril 10mg #120 is not medically necessary and appropriate.

**AMBIEN 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 (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Zolpidem.

**Decision rationale:** The MTUS Guidelines does not address this issue. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. The Official Disability Guidelines (ODG) identifies Ambien (Zolpidem) as a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Within the medical information available for review, there is documentation of a diagnosis of chronic left sided low back pain. However, there is no

documentation of insomnia. In addition, given documentation of records reflecting prescriptions for Zolpidem since at least 8/29/12, there is no documentation of the intention to treat over a short course (less than two to six weeks). Furthermore, despite documentation of low back pain that is about 7/10 to 8/10, coming down to 4/10 to 5/10 with medications, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Ambien use to date. The request for Ambien 10mg #30 is not medically necessary and appropriate.