

<b>Case Number:</b>	CM14-0154619		
<b>Date Assigned:</b>	09/24/2014	<b>Date of Injury:</b>	02/25/2009
<b>Decision Date:</b>	11/12/2014	<b>UR Denial Date:</b>	09/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/22/2014

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Texas & Florida. 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 54 year old female who was injured on 2/25/2009. The diagnoses are low back pain and post laminectomy back syndrome. The patient reported 80% reduction in pain, decrease in medications requirement and increased physical functions following transforaminal epidural steroid injections in 2013. The MRI of the lumbar spine showed degenerative disc disease and post laminectomy changes. The EMG/NCS showed right S1 radiculopathy. On 9/3/2014, [REDACTED] noted subjective complaints of low back pain radiating to the lower extremities. There was no detail on physical examination findings. The patient was waiting for neurosurgical appointment for evaluation. The medications are Ketoprofen, Hydrocodone and topical Voltaren for pain. A Utilization Review determination was rendered on 9/17/2014 recommending modified certification for hydrocodone/APAP 5/325mg #60 to #30 and denied Cyclobenzaprine 7.5mg.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone/APAP 5/325mg 1 tab by mouth daily as needed #60:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 64, 78-80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that opioids can be utilized for maintenance treatment of chronic musculoskeletal pain when the patient have exhausted standard treatment with NSAIDs, PT and surgical options. The records indicate that the patient have completed lumbar surgery, PT and non-opioids medications. There was no report of aberrant behavior of adverse medication effects. Therefore criteria for the use of Hydrocodone/325mg #60 were met.

**Cyclobenzaprine hydrochloride 7.5mg 1 tab by mouth at bedtime as needed #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available) Page(.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that muscle relaxants can be utilized for the treatment of exacerbation of chronic pain that did not respond to standard treatment with NSAIDs and PT. The chronic use of muscle relaxants is associated with the development of tolerance, dependency, addiction and adverse interactions with opioids and sedatives. The records indicate that the patient have utilized cyclobenzaprine longer that the guidelines recommended maximum duration of 4 weeks. Therefore criteria for the use of Cyclobenzaprine 7.5mg #90 were not met. mum duration of 4 weeks. The criteria for the use of cyclobenzaprine 7.5mg #90 was not met.