

<b>Case Number:</b>	CM14-0129853		
<b>Date Assigned:</b>	09/22/2014	<b>Date of Injury:</b>	05/19/2001
<b>Decision Date:</b>	10/22/2014	<b>UR Denial Date:</b>	08/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/14/2014

### 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 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 female with a 5/19/01 date of injury. At the time (7/2/14) of the request for authorization for Norco 10/325mg #60 with 3 refills, Gabapentin 600mg #90 with 3 refills, Flexeril 10mg #60 with 3 refills, and in office intramuscular injections 2 cc Toradol and 2 cc of B12 complex, there is documentation of subjective (low back pain has increased in nature) and objective (tenderness in the paraspinous musculature of the lumbar region, midline tenderness is noted in the lumbar region, decreased lumbar spine range of motion, sensation testing with a pinwheel is slightly abnormal) findings, current diagnoses (chronic back pain, status post two-level posterior lumbar interbody fusion; status post removal of hardware, regrafting and refusion L4-5; anxiety/depression; right hip trochanteric bursitis; and morbid obesity), and treatment to date (medication including opioids, Gabapentin, and Flexeril for at least a year). Medical reports identify Norco has been effective because it reduces the pain to the point where it allows the patient to perform some activities of daily living. Regarding Norco 10/325mg #60 with 3 refills, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Regarding Gabapentin 600mg #90 with 3 refills, 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 with Gabapentin use to date. Regarding Flexeril 10mg #60 with 3 refills, 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 with Flexeril use to date; and the intention to treat over a short course (less than two weeks).

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg #60 with 3 refills.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**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 diagnoses of chronic back pain, status post two-level posterior lumbar interbody fusion; status post removal of hardware, re-grafting and re-fusion L4-5; anxiety/depression; right hip trochanteric bursitis; and morbid obesity. In addition, to the given documentation that Norco has been effective because it reduces the pain to the point where it allows the patient to perform some activities of daily living; there is documentation of functional benefit with Norco use to date. 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; there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Therefore, based on guidelines and a review of the evidence, the request for Norco 10/325mg #60 with 3 refills is not medically necessary.

**Gabapentin 600mg #90 with 3 refills.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin), Page(s): 18-19. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain, as criteria necessary to support the medical necessity of Neurontin (gabapentin). 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 diagnoses of chronic back pain, status post two-level posterior lumbar interbody fusion; status post removal of hardware, re-grafting and re-fusion L4-5; anxiety/depression; right hip trochanteric bursitis; and morbid obesity. In addition, there is documentation of neuropathic pain. However, given documentation of treatment with Gabapentin for at least a year, 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 with Gabapentin use to date. Therefore, based on guidelines and a review of the evidence, the request for Gabapentin 600mg #90 with 3 refills is not medically necessary.

**Flexeril 10mg #60 with 3 refills.:** 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): 41-42. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain) Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies that Cyclobenzaprine 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. 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 diagnoses of chronic back pain, status post two-level posterior lumbar interbody fusion; status post removal of hardware, re-grafting and re-fusion L4-5; anxiety/depression; right hip trochanteric bursitis; and morbid obesity. In addition, there is documentation of acute exacerbation of chronic low back pain. However, 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 with Cyclobenzaprine use to date. Furthermore, given documentation of treatment with Cyclobenzaprine for at least a year, there is no documentation of the intention to treat over a short course (less than two weeks). Therefore, based on guidelines and a review of the evidence, the request for Flexeril 10mg #60 with 3 refills is not medically necessary.

**In office intramuscular injections 2 cc Toradol and 2 cc of B12 complex:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 72. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Ketorolac (Toradol), NSAIDs and Vitamin B12

**Decision rationale:** Regarding Toradol, MTUS Chronic Pain Medical Treatment Guidelines identifies that Ketorolac (Toradol) is not indicated for minor or chronic painful conditions. ODG identifies documentation of moderately severe acute pain that requires analgesia at the opioid level, as criteria necessary to support the medical necessity of Ketorolac injection. In addition, ODG identifies that Ketorolac, when administered intramuscularly, may be used as an alternative to opioid therapy. Regarding Vitamin B12, MTUS does not address this issue. ODG identifies that vitamin B12 is not recommended; that it is frequently used for treating peripheral neuropathy but its efficacy is not clear. Within the medical information available for review, there is documentation of diagnoses of chronic back pain, status post two-level posterior lumbar interbody fusion; status post removal of hardware, re-grafting and re-fusion L4-5; anxiety/depression; right hip trochanteric bursitis; and morbid obesity. In addition, there is documentation of moderately severe acute pain that requires analgesia at the opioid level. However, evidence based guidelines do not recommend Vitamin B12. Therefore, based on guidelines and a review of the evidence, the request for in office intramuscular injections 2 ccs Toradol and 2 ccs of B12 complex is not medically necessary.