

<b>Case Number:</b>	CM14-0007431		
<b>Date Assigned:</b>	02/12/2014	<b>Date of Injury:</b>	10/25/1991
<b>Decision Date:</b>	11/19/2014	<b>UR Denial Date:</b>	12/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/16/2014

### 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 Occupational Medicine 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:

The patient is a 61 year-old male with date of injury 10/25/1991. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 12/11/2013, lists subjective complaints as pain in the low back. Objective findings: Examination of the lumbar spine revealed tenderness to palpation of the paravertebral muscles and facet joint line with spasm. Range of motion was restricted and painful. Straight leg raising test was negative. Reflexes were symmetrical and equal. Diagnoses include chronic low back pain; lumbar disc disease; lumbar spondylosis; lumbago; and displacement of lumbar intervertebral disc without myelopathy. The medical records supplied for review document that the patient has been taking the following medications for at least as far back as six months. Medications include Chlorzoxazone 500mg #60 SIG: BID; Hydrocodone/APAP 10/325mg #110 SIG: TID; and Naproxen 500mg, #60 SIG: BID.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chlorzoxazone 500mg #60 (30 Day Supply): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines states that muscle relaxants are recommended with caution only on a short-term basis. The patient has been taking Chlorzoxazone for at least 6 months, far longer than the short-term course recommended by the MTUS. Therefore, Chlorzoxazone 500mg #60 (30 Day Supply) is not medically necessary.

**Naproxen 500mg #60 (30 Day Supply):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines recommends NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence of long-term effectiveness for pain or function. There is no documentation that the patient has achieved any functional improvement by taking Naprosyn. Naproxen 500mg #60 (30 Day Supply) is not medically necessary.

**Hydrocodone/APAP 10/325MG #110 (27 Day Supply):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-94.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of narcotics, the patient has reported very little functional improvement over the course of the last 6 months. Therefore, Hydrocodone/APAP 10/325mg #110 (27 Day Supply) is not medically necessary.