

<b>Case Number:</b>	CM14-0100624		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	05/06/1999
<b>Decision Date:</b>	09/25/2014	<b>UR Denial Date:</b>	06/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2014

### 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 Physical Medicine and Rehabilitation and Pain 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 injured worker is a 54-year-old female, who reported an injury on 05/06/1999. The mechanism of injury was not provided for clinical review. The diagnoses include chronic lower extremity pain, left lower extremity pain. The previous treatments included medication, sacroiliac joint injections, and facet joint injections. Within the clinical note dated 06/24/2014 it was reported the injured worker complained of lumbar spine and left lower extremity pain. The injured worker rated her pain at 7/10 to 9/10 in severity. Upon the physical examination, the provider noted the injured worker had an increased tone over the left paraspinous musculature of the distal thoracic and lumbar region. The provider noted cramping and uncomfortable muscle spasms in the left lateral and posterior thigh. Provider requested methocarbamol for muscle spasms. The Request for Authorization was submitted on 07/03/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Methocarbamol 750mg, #120 with 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63, 64.

**Decision rationale:** The request for Methocarbamol 750mg, #120 with 3 refills is not medically necessary. The California MTUS Guidelines recommend nonsedating muscle relaxants as a second line option for short term treatment of acute exacerbation in patients with chronic low back pain. The guidelines state that the medication is not recommended to be used for longer than 2 to 3 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The injured worker has been utilizing the medication since at least June 2014, which exceeds the guidelines' recommendation of short term use of 2 to 3 weeks. Additionally, the request submitted failed to provide the frequency of the medication. Therefore, the request is not medically necessary.