

<b>Case Number:</b>	CM14-0150950		
<b>Date Assigned:</b>	09/19/2014	<b>Date of Injury:</b>	02/10/2005
<b>Decision Date:</b>	10/24/2014	<b>UR Denial Date:</b>	08/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/16/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Texas and Ohio. 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 49-year-old female who reported an injury on 07/01/2005 due to an unspecified mechanism. Diagnosis was cervical disc. Physical examination on 08/04/2014 revealed sensory was intact to pinprick. Finger to nose, gait and station were normal. Reflexes were depressed but generally symmetrical. The neck revealed moderate tenderness in the right paravertebral muscles. There was restriction of flexion, as well as rotation because of discomfort. Lateral tilt to the neck increased pain. Range of motion of the shoulder appeared normal. Treatment plan was to take medications as directed and continue with home exercise program. The rationale was not submitted. The Request for Authorization was submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Skelaxin 800mg, #60, 6 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants, Skelaxin.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepine Page(s): 24.

**Decision rationale:** The request for Skelaxin 800mg, #60, 6 refills is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines do not recommend the use of

benzodiazepines as treatment for patients with chronic pain for longer than 3 weeks due to a high risk of psychological and physiological dependency. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time. Therefore, continued use would not be supported. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, this request is not medically necessary.