

<b>Case Number:</b>	CM14-0167560		
<b>Date Assigned:</b>	10/14/2014	<b>Date of Injury:</b>	12/04/2002
<b>Decision Date:</b>	11/24/2014	<b>UR Denial Date:</b>	09/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/10/2014

### 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:

According to the records made available for review, this is a 63-year-old male with a 12/4/02 date of injury. At the time (8/22/14) of request for authorization for Robaxin 750mg #60 x 2 refills and Percocet 10/325 #120 x 2 refills, there is documentation of subjective (chronic low back pain with difficulty performing activities of daily living) and objective (unstable gait, tenderness to palpation over the lumbar paraspinal muscles with severe stiffness, tenderness over the buttocks and right sacroiliac joint, and decreased strength of the right lower extremity) findings, current diagnoses (mechanical low back pain, bilateral sacroiliitis, chronic left L5 radiculopathy, severe lumbar foraminal stenosis, myofascial pain syndrome, lumbar degenerative disc disease, multilevel central and foraminal stenosis, right foot drop, and new onset right leg weakness), and treatment to date (ongoing therapy with Percocet and Robaxin since at least 6/2/14 with decreased pain levels). Regarding Robaxin 750mg #60 x 2 refills, there is no documentation of spasticity or acute exacerbation of chronic low back pain, short-term (less than two weeks) treatment, and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Robaxin use to date. Regarding Percocet 10/325 #120 x 2 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; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Percocet use to date.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Robaxin 750mg #60 x 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-64. 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 documentation of acute exacerbation of chronic low back pain and used as a second line option for short-term treatment, as criteria necessary to support the medical necessity of muscle relaxant. 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 for short-term (less than two weeks) treatment. Within the medical information available for review, there is documentation of diagnoses of mechanical low back pain, bilateral sacroiliitis, chronic left L5 radiculopathy, severe lumbar foraminal stenosis, myofascial pain syndrome, lumbar degenerative disc disease, multilevel central and foraminal stenosis, right foot drop, and new onset right leg weakness. In addition, there is documentation of chronic low back pain. However, there is no documentation of spasticity or acute exacerbation of chronic low back pain. In addition, given documentation of ongoing treatment with Robaxin since at least 6/2/14, there is no documentation of short-term (less than two weeks) treatment. Furthermore, despite documentation of decreased pain levels with Robaxin, there is no (clear) 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 as a result of Robaxin use to date. Therefore, based on guidelines and a review of the evidence, the request for retrospective request for Robaxin 750mg #60 x 2 refills is not medically necessary.

**Percocet 10/325 #120 x 2 refills:** Upheld

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

**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 mechanical low back pain, bilateral sacroiliitis, chronic left L5 radiculopathy, severe lumbar foraminal stenosis, myofascial pain syndrome, lumbar degenerative disc disease, multilevel central and foraminal stenosis, right foot drop, and new onset right leg weakness. 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; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, despite documentation of ongoing treatment with Percocet since at least 6/2/14 with decreased pain levels, there is no (clear) 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 as a result of Percocet use to date. Therefore, based on guidelines and a review of the evidence, the request for Percocet 10/325 #120 x 2 refills is not medically necessary.