

<b>Case Number:</b>	CM14-0040537		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	08/14/2001
<b>Decision Date:</b>	07/17/2014	<b>UR Denial Date:</b>	02/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/10/2014

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 53-year-old male who reported an injury on 08/14/2001. The mechanism of injury was not provided within the medical records. The clinical note dated 05/15/2014 indicated diagnosis of neck strain. The injured worker reported chronic neck pain with decreased activity. The injured worker reported Skelaxin helped with his headaches and muscle spasms in the past and enabled him to sleep better and be more active in the day time. On physical examination of the cervical spine, the injured worker had decreased flexion and rotation to the left, increased spasms to the posterior neck area right greater than left, with weak grip to the right hand. The injured worker's prior treatments included diagnostic imaging and medication management. The injured worker's medication regimen included Norco and naproxen. The provider submitted a request for Norco, tizanidine, and naproxen. A Request for Authorization dated 04/08/2014 was submitted for Norco, tizanidine, and naproxen; however, a rationale was not provided for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325 mg # 180:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 78.

**Decision rationale:** The California MTUS Guidelines recommend the use of opioids for the on-going management of chronic low back pain. The ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is a lack of significant evidence of an objective assessment of the injured worker's pain level, functional status, and evaluation of risks for aberrant drug use behaviors and side effects. Furthermore, the request does not indicate a frequency for the medication. Therefore, the request for Norco is not medically necessary.

**Tizanidine 4 mg # 60:** Upheld

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

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

**Decision rationale:** The California Chronic Pain Medical Treatment Guidelines state muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP and muscle spasms. This medication is not recommended to be used for longer than 2-3 weeks. The injured worker reported muscle spasms and would benefit from a muscle relaxer; however, the request did not indicate a frequency for the medication; therefore, the request for Tizanidine 4 mg # 60 is not medically necessary.

**Naprosyn 500 mg # 60:** Upheld

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

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

**Decision rationale:** The California Chronic Pain Medical Treatment Guidelines state Naprosyn is indicated for Osteoarthritis or ankylosing spondylitis and moderate to severe pain. The guidelines also state the lowest effective dose should be sought for each patient. The injured worker does report pain; however, there is lack of a quantified pain assessment. In addition, the request did not indicate a frequency for the medication. Therefore, the request is not medically necessary.