

<b>Case Number:</b>	CM15-0003490		
<b>Date Assigned:</b>	01/14/2015	<b>Date of Injury:</b>	11/18/2004
<b>Decision Date:</b>	03/10/2015	<b>UR Denial Date:</b>	12/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: New York

Certification(s)/Specialty: Internal Medicine

### 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 61 year old female, who sustained a work/ industrial injury on 11/18/2004 when a rack of clothing fell on her. She has reported symptoms of pain to low back, left hip, left leg, and left arm pain. Headaches were also reported. Pain was 4-5/10. The diagnoses have included arthropathy, spinal stenosis, and lumbar spondylosis without myelopathy. Past medical history includes arthritis, hypertension, depression, bipolar disorder, anxiety, and cardiac arrhythmia. Treatment to date has included medications, surgical procedures (SI joint injections, radiofrequency rhizotomy of the lumbar medial branch nerves, bilateral C3, C4 radiofrequency neurotomies, and left C2-C4 facet injections), exercises, and pain management. Diagnostics included an magnetic resonance imaging (MRI) of the lumbar spine to report slight paracentral disc bulge at T11-12, slight central bulge at L1-2, L2-3 left paracentral disc herniation, L3-4 broad straight disc bulge; cervical MR I noted increased lordotic curve in c-spine, mild spondylolytic changes. On 11/26/14, the treating physician ordered medication to include: Robaxin 750 mg #60 with 1 refill and Naproxen 500 mg #60 with 1 refill. On 12/8/14, Utilization Review non-certified Robaxin 750 mg #60 with 1 refill and Naproxen 500 mg #60 with 1 refill, noting the Medical treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Robaxin 750mg #60 refill 1:** 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): 41 ( pdf format).

**Decision rationale:** Per California MTUS Treatment Guidelines, Robaxin is not recommended for the long-term treatment of low back pain. The medication has its greatest effect in the first four days of treatment. The documentation does not indicate there are palpable muscle spasms and there is no documentation of functional improvement from any previous use of this medication. Per California MTUS Guidelines muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory medications alone. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested item is not medically necessary.

**Naproxen 500mg #60 refill 1:** Overturned

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

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

**Decision rationale:** The requested medication, Naproxen is medically necessary for the treatment of the claimant's pain condition. Naproxen is a non-steroidal anti-inflammatory medication ( NSAID). These medications are recommended for the treatment of chronic pain as a second line therapy after acetaminophen. The documentation indicates the claimant has significant musculoskeletal pain and the medication has proved beneficial for pain control especially during an exacerbation of her chronic pain condition. Medical necessity for the requested medication has been established. The requested treatment is medically necessary.