

<b>Case Number:</b>	CM15-0011139		
<b>Date Assigned:</b>	01/29/2015	<b>Date of Injury:</b>	04/02/2002
<b>Decision Date:</b>	03/27/2015	<b>UR Denial Date:</b>	01/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2015

### 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: California, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 46-year-old male who reported an injury on 08/06/2001 due to an unspecified mechanism of injury. On 12/18/2014, he presented for a followup evaluation. He reported arm pain, left shoulder pain, and neck and back pain. He stated that his medications included Lyrica, Robaxin, tizanidine, and Norco allowed him to function and reported a 60% relief from the opioids. His medications included hydrocodone/acetaminophen 1 time by mouth every 4 hours as needed for pain, tizanidine 1 tab by mouth at bedtime as needed, methocarbamol 1 tab by mouth 4 times a day as needed, tizanidine HCl take by mouth, naproxen sodium 1 tab by mouth daily, omeprazole 1 time by mouth daily, and docusate sodium 1 tab by mouth daily. A physical examination showed limited range of motion with the ability to flex to 40 degrees with a normal of 40 degrees and extend to 20 degrees with normal of 40 degrees, rotate right to 60 degrees with a normal of 60 degrees, and left rotate to 30 degrees with a normal of 60 degrees. There were palpable muscle spasms in the sternocleidomastoid and superior trapezius and his motor strength was a 5/5 throughout. He was diagnosed with postlaminectomy syndrome of the cervical region, postlaminectomy syndrome of the lumbar region, brachial neuritis or radiculitis, thoracic or lumbosacral neuritis or radiculitis, and spasms of the torticollis. The treatment plan was for Norco, Zanaflex, and Robaxin. The rationale for treatment was to continue to treat the injured worker's symptoms.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325mg one(1)q4 hrs pain #130:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids: Therapeutic trial of Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Chapter, Testosterone replacement for hypogonadism

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-Going management Page(s): 78.

**Decision rationale:** The California MTUS Guidelines indicate that an ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be performed during opioid therapy. Based on the clinical documentation submitted for review, the injured worker was noted to be symptomatic and reported that his medications provided him with 60% relief of pain. However, there is a lack of objective evidence showing that he is having an objective improvement in function with the use of these medications to support their continuation. Also, no official urine drug screens or CURES reports were provided for review to validate his compliance with the medication regimen. In the absence of this information, the request would not be supported by the evidence based guidelines. As such, the request is not medically necessary.

**Zanaflex 4mg one(1)qhs #30 x 1 refill:** Upheld

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

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

**Decision rationale:** The California MTUS Guidelines indicate that muscle relaxants are recommended for the short term symptomatic relief of low back pain. Based on the clinical information submitted for review, the injured worker was noted to have reported a decrease in his pain with the use of his medications. However, there is a lack of documentation showing that he has tried and failed first line therapy medications to support the request. Also, the duration of use with this medication was not stated within the documentation. Without knowing how long he has been using this medication, its continuation would not be supported as it is only recommended for short term use. Furthermore, a refill of the medication would not be supported without a re-evaluation to determine treatment success. Therefore, the request is not supported. As such, the request is not medically necessary.

**Robaxin 750mg one(1) quid #120 x 1 refill:** Upheld

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

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

**Decision rationale:** The California MTUS Guidelines indicate that muscle relaxants are recommended for the short term symptomatic relief of low back pain. Based on the clinical information submitted for review, the injured worker was noted to have reported a decrease in his pain with the use of his medications. However, there is a lack of documentation showing that he has tried and failed first line therapy medications to support the request. Also, the duration of use with this medication was not stated within the documentation. Without knowing how long he has been using this medication, its continuation would not be supported as it is only recommended for short term use. Furthermore, a refill of the medication would not be supported without a re-evaluation to determine treatment success. Therefore, the request is not supported. As such, the request is not medically necessary.