

<b>Case Number:</b>	CM15-0122867		
<b>Date Assigned:</b>	07/07/2015	<b>Date of Injury:</b>	03/21/2003
<b>Decision Date:</b>	08/04/2015	<b>UR Denial Date:</b>	06/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/25/2015

### 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

Certification(s)/Specialty: Preventive Medicine, Occupational 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 73 year old male, who sustained an industrial injury on March 21, 2003, incurring neck and shoulder injuries. He was diagnosed with a cervical spine sprain with bulging discs and a left rotator cuff tear. He underwent a left shoulder arthroscopic debridement of the rotator cuff tear with decompression, a Bursectomy and joint resection. Treatments included pain medications, anti-inflammatory drugs, surgical interventions, and work restrictions and modifications. Currently, the injured worker complained of persistent neck and left shoulder pain with overhead activities. He rated his pain a 9 out of 10 and complained of limited range of motion of the cervical spine and left shoulder. The treatment plan that was requested for authorization included prescriptions for Norco and Robaxin.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325 MG #80:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 74-94.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of Norco, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 6 months. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of narcotic. Norco 10/325 MG #80 is not medically necessary.

**Robaxin 750 MG #25:** Upheld

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

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

**Decision rationale:** The MTUS states that muscle relaxants are recommended with caution only on a short-term basis. The patient has been taking the muscle relaxant for an extended period of time far longer than the short-term course recommended by the MTUS. There is no reported functional improvement. At present, based on the records provided, and the evidence-based guideline review, the request is non-certified. Robaxin 750 MG #25 is not medically necessary.