

<b>Case Number:</b>	CM14-0150705		
<b>Date Assigned:</b>	09/25/2014	<b>Date of Injury:</b>	01/24/2008
<b>Decision Date:</b>	11/04/2014	<b>UR Denial Date:</b>	09/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/16/2014

### 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 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 51-year-old female with a reported date of injury on 01/24/2008. The mechanism of injury was not submitted within the medical records. Her diagnoses were noted to include lumbar disc disease, lumbar facet syndrome and bilateral sacroiliac joint arthropathy. Her previous treatments were noted to include medial branch blocks, medications, pool therapy, acupuncture and TENS unit. The progress note dated 07/31/2014 revealed complaints of low back pain that increased with sitting, standing, and twisting. The physical examination revealed a positive straight leg raise and decreased range of motion. There was positive muscle spasms noted. The injured worker indicated with pain medication she was able to perform her activities of daily living and with medications her pain rated 6/10 and without medications rated 8/10 to 9/10. The Request for Authorization form dated 07/31/2014 was for Robaxin 750 mg #120 for muscle spasms.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Robaxin 750 mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Procedure Summary

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

**Decision rationale:** The request for Robaxin 750 mg #120 is not medically necessary. The injured worker has been utilizing this medication since at least 04/2014. The California MTUS Chronic Pain Medical Treatment Guidelines recommend muscle relaxants as a second line option for short term treatment of acute low back pain and their use if recommended for less than 3 weeks. There should be documentation of objective functional improvement and the clinical documentation submitted for review provides evidence that the injured worker has been on this medication for an extended duration of time. There is a lack of documentation regarding objective functional improvement with utilization of this medication. Therefore, continued use of this medication would not be supported. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.