

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM14-0108699 |                              |            |
| <b>Date Assigned:</b> | 08/01/2014   | <b>Date of Injury:</b>       | 09/10/2012 |
| <b>Decision Date:</b> | 09/29/2014   | <b>UR Denial Date:</b>       | 06/30/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 07/14/2014 |

### 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 Texas and Oklahoma 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 45-year-old male who reported an injury on 09/10/2012 due to an unknown mechanism. Diagnoses were sprain/strain both wrists, sprain/strain both knees, sprain/strain of the lumbar spine. Past treatments were physical therapy, chiropractic treatment, injections, extracorporeal shockwave therapy. Diagnostic studies were Nerve Conduction Studies and a Pseudo scan. Surgical history was not reported. Physical examination on 06/04/2014 revealed complaints of left knee pain, left and right wrist pain, and low back pain. Examination of the left knee revealed range of motion was 0 to 120 degrees, McMurray's was negative. Examination of bilateral wrists revealed no palpable masses. Examination of the low back revealed 25% range of motion. Medications were not reported. Treatment plan was for cyclobenzaprine 7.5. The rationale and request were not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cyclobenzaprine 7.5mg #150:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Cyclobenzaprine Page(s): 41, 64.

**Decision rationale:** The decision for cyclobenzaprine 7.5 mg, quantity 150, is not medically necessary. The California Medical Treatment Utilization Schedule states that cyclobenzaprine (Flexeril) is recommended for a short course of therapy. Flexeril is more effective than placebo in the management of back pain. However, the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. This medication is not recommended to be used for longer than 2 to 3 weeks. The efficacy of this medication was not reported. Also, the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.