

<b>Case Number:</b>	CM14-0161664		
<b>Date Assigned:</b>	10/07/2014	<b>Date of Injury:</b>	07/20/2004
<b>Decision Date:</b>	11/10/2014	<b>UR Denial Date:</b>	09/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/01/2014

### 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 and Rehabilitation, has a subspecialty in Pain Medicine 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 53 year old male who reported injury on 07/20/2004. The mechanism of injury reportedly occurred while the injured worker was driving a forklift that lost its tire and the fork lift dropped causing impact to his lower back. His diagnoses included lumbar spondylosis and lumbar disc displacement. Past treatments included medication, physical therapy, and behavioral health therapy. On 09/29/2014 the injured worker had complaints of pain rated 8/10 to his lower back. He stated that the medication was helping, but he felt his condition was worsening. The injured worker also reported loss of bowel and bladder control. The physical examination showed only 25 percent of voluntary spine motion in the lumbar area, a positive straight leg raise to the right lower extremity, and decreased sensation to the lower extremities below his knees, and gait was slightly antalgic. His medication regimen included Flexeril, gabapentin, Metaxalone and Norco. The physician's treatment plan included the recommendation that the injured worker continue his medication regimen as it optimized function and activities of daily living. A request was received for Flexeril 10mg dispense 90. The requesting physician's rationale for the request was not indicated within the provided documentation. The request for authorization was dated 09/29/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flexeril 10mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42.

**Decision rationale:** The Request for Flexeril 10mg quantity 90 is not certified. The California MTUS guidelines recommend Flexeril as an option for a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. In the documentation provided the injured worker has been using the medication for longer than 6 months with no supportive documentation as to why he is taking the medication. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the medication. There is a lack of documentation indicating the injured worker has significant spasms upon physical examination. Additionally, the request does not indicate the frequency at which the medication is prescribed in order to determine the necessity of the medication. As such, the request is not medically necessary.