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| Case Number: | CM14-0030935 | | |
| Date Assigned: | 03/21/2014 | Date of Injury: | 11/19/2004 |
| Decision Date: | 08/08/2014 | UR Denial Date: | 02/10/2014 |
| Priority: | Standard | Application Received: | 03/11/2014 |

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 Anesthesiology, has a subspecialty in Pain Medicine, and is licensed to practice in Texas. 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 46 year old male injured on 11/19/04 due to undisclosed mechanism of injury. Current diagnoses included post-laminectomy syndrome, lumbar disc displacement without myelopathy, lumbosacral neuritis, lumbago, and long term use of medications. Clinical note dated 01/15/14 indicated the injured worker presented complaining of low back and leg pain. The injured worker utilized spinal cord stimulator which improved his pain and continued to work well at times; however, the injured worker experienced increases in intensity of stimulation. This had an onset gradually over greater than one year. There were no objective findings provided for review. Clinical note dated 12/18/13 indicated the injured worker presented with low back pain. Objective findings on that date indicated the injured worker ambulated without assistance and was able to sit comfortably on the examination table without difficulty. There was no additional objective findings provided for review. Medications included pantoprazole 20mg twice daily, Trazadone 50mg at night, hydrocodone/acetaminophen 5-325mg PRN, cyclobenzaprine 7.5mg twice daily, Lopid 100mg daily, metformin, and Enalapril. The initial request for Flexeril 5mg #60 was non-certified on 02/10/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 PRESCRIPTION OF FLEXERIL 5MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines FLEXERIL (R) (CYCLOBENZAPRINE); MUSCLE RELAXANTS (FOR PAIN).

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

Decision rationale: As noted on page 41 of the Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine is recommended as a second-line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Studies have shown that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Based on the clinical documentation, the injured worker has exceeded the 2-4 week window for acute management also indicating a lack of efficacy if being utilized for chronic flare-ups. Additionally, the physical examination failed to provide objective findings significant for spasm necessitating the use of muscle relaxants. As such, the medical necessity of Flexeril 5MG #60 cannot be established and is not medically necessary and appropriate.