

<b>Case Number:</b>	CM14-0093630		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	11/16/1997
<b>Decision Date:</b>	09/09/2014	<b>UR Denial Date:</b>	06/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/20/2014

### 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 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 62-year-old female who reported an injury on 11/16/1997 due to an unknown mechanism. The diagnoses were status post bilateral total knee arthroplasty, and compensatory low back pain secondary to gait alteration. The past treatments were massage, physical therapy and TENS unit. Diagnostic studies were not submitted. Surgical history was status post bilateral total knee arthroscopy. The injured worker had a physical examination on 07/15/2014, with complaints of knee pain. She denied any radicular symptoms. She denied any severe muscle spasms. The injured worker rated her pain at a 4-5 out of 10 with current medication. Without medication, she rated her pain at a 9/10. She stated functional improvement as well as improvement in pain with her current medications. It was noted there was improvement in the ability to participate in activities of daily living. Examination of the low back revealed bilateral lumbar paraspinus, tenderness from the L4 through the S1. There were no palpable muscle spasms. There was a negative twitch response. Examination of the lumbar spine range of motion revealed flexion was to 60 degrees, extension was to 20 degrees, right lateral flexion was to 20 degrees, and left lateral flexion was to 20 degrees. Knee examination revealed a well healed scar at both knees, with no severe pinpoint tenderness. Medications were Synthroid, hydrochlorothiazide, Flexeril 10 mg, as needed, meloxicam 7.5 mg, 1 to 2 daily, Vicodin 5/500, 1 to 2 tablets twice a day as needed for breakthrough pain. Treatment plan was to continue with medications as directed and to continue use of the TENS unit for symptomatic relief of pain. The rationale and Request for Authorization form were not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flexeril 10mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64-66.

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

**Decision rationale:** The request for Flexeril 10 mg is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend muscle relaxants as a second line option for the short treatment of acute low back pain and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration of time and there is a lack of documentation of objective improvement. Therefore, continued use of this medication would not be supported. Also, the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.

**Random urine drug screening:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management Page(s): 78.

**Decision rationale:** The request for a random urine drug screening is non-certified. The California Medical Treatment Utilization Schedule Guidelines state that the use of urine drug screening is for patients with documented issues of abuse, addiction, or poor pain control. There was no documentation of aberrant drug behavior. Therefore, the request is not medically necessary.