

<b>Case Number:</b>	CM14-0095541		
<b>Date Assigned:</b>	09/22/2014	<b>Date of Injury:</b>	09/03/2002
<b>Decision Date:</b>	10/24/2014	<b>UR Denial Date:</b>	06/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/23/2014

### 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 Ohio. 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 49-year-old male who reported an injury on 09/30/2002. The mechanism of injury was not submitted for clinical review. The diagnoses included lumbar disc displacement without myelopathy, unspecified major depression and neuritis lumbosacral. The previous treatments included medication. Within the clinical note dated 09/03/2014, it was reported the injured worker complained of chronic back pain and leg pain. He reported the leg pain on the right side was worse after surgery. He complained of pain radiating his left lower extremity, down his foot. He rated his pain 5/10 in severity with medication and 10/10 without medication. Upon the physical examination, the provider noted the injured worker had normal muscle tone. There was decreased sensation in the L2, L3 and left L4, left L5 and S1 dermatomes. The provider requested Baclofen. However, a rationale was not submitted for clinical review. The Request for Authorization was submitted and dated 09/15/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Baclofen 10mg #90 with 3 refills:** 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 Muscle Relaxants, Page(s): 63, 64..

**Decision rationale:** The California MTUS Guidelines recommend nonsedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbation in patients with chronic low back pain. The guidelines do not recommend the medication to be used for longer than 2 to 3 weeks. There is lack of documentation indicating the efficacy of the medication as evidence by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, Baclofen 10 mg #90 with 3 refills is not medically necessary.