

<b>Case Number:</b>	CM14-0195637		
<b>Date Assigned:</b>	12/03/2014	<b>Date of Injury:</b>	03/26/2004
<b>Decision Date:</b>	01/15/2015	<b>UR Denial Date:</b>	10/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/21/2014

### 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, has a subspecialty in Interventional Spine and is licensed to practice in California. 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 patient is a 60 year old male with an injury date of 03/24/04. Based on the 05/06/14 progress report, the patient complains of pain in his neck and bilateral lower extremities which is associated with numbness and tingling. He rates his pain as a 5/10 and describes his pain as being frequent and dull. The 08/05/14 report states that the patient has tenderness to palpation over the suboccipital muscle, paravertebral musculature, and trapezius muscles of the cervical spine. Paraspinal muscle guarding is present with palpation and passive ranging. In regards to the bilateral shoulders, there is tenderness to palpation over the anterior capsule and periscapular muscles, left worse than right. Sensation to pinprick and light touch is decreased in the bilateral upper extremities along the C6 and C7 dermatomal distribution. The 10/02/14 report indicates that the patient's pain is moderate and frequent. Axial Compression test is positive and elicits neck pain and left upper extremity pain. The patient's diagnoses include the following: 1) status post anterior cervical discectomy and fusion at C5-C6 and C6-C7, 06/07/072) solid fusion/cord gliosis at C6-C7 and solid fusion at C5-C6, per MRI scan 07/30/123) status post discectomy and fusion at C3-C4, performed on 0509/13 The utilization review determination being challenged is dated 10/22/14. Treatment reports were provided from 03/24/14- 11/10/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 prescription of Fexmid 7.5mg #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66.

**Decision rationale:** The patient presents with pain in his cervical spine and in his bilateral lower extremities. The request is for 1 PRESCRIPTION OF FEXMID 7.5 MG #60. The patient has been taking Fexmid as early as 05/06/14. MTUS pg 63-66 states: "Muscle relaxants (for pain): Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic LBP. The most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy." Fexmid prescription was first noted in progress report dated 05/06/14. The 10/02/14 report states that the patient's "residual pain, radicular symptoms and muscle spasms are well controlled with current medication regimen. He reports adequate relief to promote sleep and improved activities of daily living and home exercise program." However, this information is not specific to Fexmid. Furthermore, MTUS guidelines do not recommend use of Cyclobenzaprine for longer than 2-3 weeks. The patient has been taking Fexmid as early as 05/06/14 which exceeds the time frame provided by MTUS guidelines. Therefore, the requested Fexmid IS NOT medically necessary.