

<b>Case Number:</b>	CM14-0212454		
<b>Date Assigned:</b>	01/02/2015	<b>Date of Injury:</b>	05/02/2013
<b>Decision Date:</b>	03/03/2015	<b>UR Denial Date:</b>	11/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/18/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, Arizona  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 43-year-old male who reported an injury on 05/02/2013 due to cumulative trauma. Diagnoses were cervical spondylosis, cervical stenosis, and bilateral carpal tunnel syndrome. The clinical note dated 11/18/2014 noted injured worker complaints of pain. Upon examination, there was full range of motion noted to the cervical spine. The muscle strength in the bilateral upper extremities was normal with intact pinprick sensation in all upper extremity dermatomes. Current medications included ibuprofen and Zanaflex. Previous electrodiagnostic study performed on an unspecified date revealed no electrodiagnostic evidence of cervical axonal motor radiculopathy, brachial plexopathy, or bilateral upper extremity localized ulnar or radial sensory or motor neuropathy indicated. The provider recommended Flexeril with a quantity of 90. There was no rationale provided. The Request for Authorization form was 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 # 90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 50, 56, 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

**Decision rationale:** The request for Flexeril # 90 is not medically necessary. The California MTUS recommend nonsedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbations. Flexeril is recommended for a short course of therapy. The documentation submitted for review note that the injured worker has been on Zanaflex previously and it did not affect his symptoms. The guidelines referenced would support the use of Flexeril; however, the dose and frequency of the medication were not provided in the request as submitted. As such, medical necessity has not been established.