

<b>Case Number:</b>	CM15-0000020		
<b>Date Assigned:</b>	01/09/2015	<b>Date of Injury:</b>	12/17/1998
<b>Decision Date:</b>	03/06/2015	<b>UR Denial Date:</b>	12/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/31/2014

### 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  
 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 42 year old male, who sustained an industrial injury on December 17, 1998. He has reported low back pain resulting from repetitive bending and lifting. The diagnoses have included low back pain, status post lumbar discectomy, status post BAK cage posterior fusion, sacroiliitis and lumbar facet pain. Treatment to date has included medication, lumbar epidural blocks, physical therapy, lumbar brace and surgery. Currently, the injured worker complains of low back pain rated as a 6-7 on a 1-10 pain scale. The pain was described as a deep, achy pain associated with tightness, spasms and stiffness. He also reported radiation into the right gluteal region and radiation into the left leg describing it as sharp, shooting, deep and achy with intermittent burning and tingling. On December 18, 2014, Utilization Review non-certified one prescription of Cyclobenzaprine 10mg #60, noting the MTUS Guidelines. On December 31, 2014, the injured worker submitted an application for IMR for review of one prescription of Cyclobenzaprine 10mg #60.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cyclobenzaprine 10 MG #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, pg 128.

**Decision rationale:** Submitted reports have not adequately demonstrated the indication or medical need for this continued muscle relaxant medication treatment and there is no report of significant change in clinical findings, acute flare-up or new injury to support for its long-term use of this chronic 1998 injury. There is no report of functional improvement resulting from its previous treatment to support further use as the patient remains functionally unchanged. The Cyclobenzaprine 10 MG #60 is not medically necessary and appropriate.