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| Case Number: | CM15-0039196 | | |
| Date Assigned: | 03/09/2015 | Date of Injury: | 03/02/2005 |
| Decision Date: | 04/21/2015 | UR Denial Date: | 02/13/2015 |
| Priority: | Standard | Application Received: | 03/02/2015 |

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: Pennsylvania, Ohio, 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 62 year old male, who sustained an industrial injury on 03/02/2005. He has reported low back pain. The diagnoses have included severe lumbar discopathy; left lower extremity radiculitis; and left knee pain. Treatment to date has included medications, physical therapy, epidural steroid injection, and activity modification. Medications have included Tramadol ER, Cyclobenzaprine, Ondansetron, and Omeprazole. A progress note from the treating physician, dated 01/16/2015, documented a follow-up visit with the injured worker. Currently the injured worker complains of constant pain in the low back and radiates into the lower extremities; the pain is sharp and worsening, and is rated at 7/10 on the visual analog scale. Objective findings included palpable paravertebral muscle tenderness with spasm of the lumbar spine; and tingling and numbness in the lateral thigh, anterolateral and posterior leg as well as the foot. The treatment plan has included imaging studies, physical therapy, and prescription medications. Request is being made for Cyclobenzaprine Hydrochloride tablets 7.5 mg Qty 120, 1 tablet by mouth every 8 hours.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine Hydrochloride tablets 7.5 mg Qty 120, 1 tablet by mouth every 8 hours:
 Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-64.

Decision rationale: MTUS recommends the use of non-sedating muscle relaxants for short-term use only. This guideline recommends Cyclobenzaprine/Flexeril only for a short course of therapy. The records in this case do not provide an alternate rationale to support longer or ongoing use. This request is not medically necessary.