

<b>Case Number:</b>	CM15-0049770		
<b>Date Assigned:</b>	03/23/2015	<b>Date of Injury:</b>	10/21/2012
<b>Decision Date:</b>	05/06/2015	<b>UR Denial Date:</b>	03/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/16/2015

### 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: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 37-year-old male who sustained an industrial injury on 12/23/2011. Current diagnoses include right carpal tunnel syndrome, lumbar spine disc, and thoracic spine disc. Previous treatments included medication management. Diagnostic studies included EMG/NCS on 11/05/2014 and MRI of the left and right wrist, lumbar spine, and thoracic spine on 09/04/2013. Report dated 01/21/2015 noted that the injured worker presented with complaints that included pain in mid back, lower back, and wrist. Pain level was not included. Physical examination was positive for abnormal findings. The treatment plan included surgery planned for the following day for the right wrist, return for therapy to that right wrist, and refill medications. Disputed treatment includes cyclobenzaprine 7.5 mg Qty 60.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cyclobenzaprine 7.5 mg Qty 60, take 1 tablet 2 times daily as needed:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

**Decision rationale:** According to MTUS guidelines, Cyclobenzaprine a non sedating muscle relaxants is recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic spasm and pain. Efficacy appears to diminish over time and prolonged use may cause dependence. The guidelines do not recommend to be used for more than 2-3 weeks. The patient in this case does not have clear recent evidence of spasm and the prolonged use of Cyclobenzaprine is not justified. Therefore, the request for Cyclobenzaprine 7.5mg #60 is not medically necessary.