MAXIMUS Federal Services

Case Number:	CM15-0084202		
Date Assigned:	05/06/2015	Date of Injury:	12/23/2014
Decision Date:	06/04/2015	UR Denial Date:	04/16/2015
Priority:	Standard	Application Received:	05/01/2015

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 York, Pennsylvania, Washington
Certification(s)/Specialty: Internal Medicine, Geriatric 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 was a 51 year old female, who sustained an industrial injury, December 23, 2014. The injured worker was injured in a work relate motor vehicle accident. The injured worker previously received the following treatments thoracic spine x-rays, Ibuprofen, Robaxin, active modification, sertraline, Flexeril, Naproxen, Prilosec, Percocet, Tramadol, Norco, thoracic CT scan and physical therapy for the wrists. The injured worker was diagnosed with mild T9 compression fracture with no visible retropropulsion, thoracic compression fracture, multiple sprains/strains, right ankle sprain, status post motor vehicle accident, low back pain, left foot pain, neck pain, right wrist pain and left wrist pain. According to progress note of March 30, 2015, the injured workers chief complaint was intractable low back pain with left lower extremity paresthesias. The pain was described as constant aching, sharp and stabbing. The pain was aggravated by upright position, standing, sitting, walking, bending and lifting. The relieving factors were resting, heat, icing, and medications. The limitations were described as severe with profound limitations. The back pain had radiation into the mid back, low back into the left gluteal area. The wrist pain was mild to moderate and physical therapy was helping. The foot pain was intermittent mild to moderate. The pain was aggravated by walking, standing and associated symptoms included cramping and pulsating. The diagnostic testing of the cervical spine suggested paraspinal spasms with loss of lordosis. The physical exam noted overall good alignment of the cervical spine. The treatment plan included a retroactive prescription for Flexeril.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Flexeril tab 7.5mg 1 tab PO 3x/day 30 days #90 with 1 refill: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 9792.26 Page(s): 63-66.

Decision rationale: Per the guidelines, non-sedating muscle relaxants are recommended for use with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic low back pain. Efficacy appears to diminish over time and prolonged use can lead to dependence. The MD visit fails to document any improvement in pain, functional status or a discussion of side effects specifically related to flexeril to justify use. The medical necessity of flexeril is not substantiated in the records. The request is not medically necessary.