MAXIMUS Federal Services

Case Number:	CM14-0120180		
Date Assigned:	08/06/2014	Date of Injury:	12/11/2001
Decision Date:	10/09/2014	UR Denial Date:	06/24/2014
Priority:	Standard	Application Received:	07/29/2014

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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 65 year old male who had a work related injury on 12/11/2001. Mechanism of injury is not described. The most recent document submitted for review is dated 07/28/14. The injured worker states she has been having severe pain and muscle spasm, pain shooting down into his left leg. The injured worker has been wearing a compression stocking for lower extremity swelling, which he finds helpful and uses Vicodin occasionally for pain and ibuprofen for inflammation, occasionally Flexeril for back spasms and asking for a refill of medication. Also requested was an updated magnetic resonance image of his lumbar spine which was denied through a utilization review. The injured worker is on Social Security disability, does not work, but keeps himself active as a painter and an artist. Physical examination of the low back reveals palpable muscle spasm with loss of lumbar trunk range. He can only forward flex 30 degrees, extend 5 degrees. Right and left straight leg raise is 80 degrees, causing left sided back pain that radiates into the left leg along the lateral calf and foot. He reports altered sensory loss to light touch and pinprick in the left lateral calf and bottom of his foot. He ambulates with a limp with the left lower extremity. Deep tendon reflexes are +1 at the knees and ankles. Toes are down going to plantar reflex bilaterally. There are multiple venous varicosities in the lower extremities with some trace pretibial ankle edema. Examination of both feet reveals tenderness over the plantar fascia bilaterally. Diagnosis history of low back pain with lumbar sprain/strain with radicular symptoms in the left leg, history of grade 1 spondylolisthesis defect with degenerative disc disease with disc herniation at L5-S1 with severe facet arthropathy. Distal saphenous vein stripping, left lower extremity, with ligation secondary to blood clot with partial avulsion phlebotomy with residual varicosities, venous stasis left leg. Plantar fasciitis bilaterally, stable with orthotic use. Prior utilization review on 06/21/14 was non-certified. Current request is for Flexeril 10mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexeril 10mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41 of 127.

Decision rationale: As noted on page 41 of the Chronic Pain Medical Treatment Guidelines, cyclobenzaprine is recommended as a second-line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Studies have shown that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Based on the clinical documentation, the patient has exceeded the 2-4 week window for acute management also indicating a lack of efficacy if being utilized for chronic flare-ups. As such, the medical necessity of this medication cannot be established at this time.