

<b>Case Number:</b>	CM14-0215992		
<b>Date Assigned:</b>	01/06/2015	<b>Date of Injury:</b>	02/12/2003
<b>Decision Date:</b>	02/28/2015	<b>UR Denial Date:</b>	12/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/24/2014

### 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:

This 46 year old male sustained a work related injury on 02/12/2003. The mechanism of injury was not made known. According to the oldest progress report submitted for review that was dated 07/17/2012 the injured worker used Skelaxin occasionally for back spasms. He reported some flare-up of back pain, shooting in his right hip and buttock area and persistent neck and shoulder pain. He could not bend or stoop or lift anything heavy. Progress notes submitted for review dated 07/17/2012 - 08/20/2014 noted that the injured worker's medication regimen included Skelaxin for muscle spasms. As of 08/20/2014, physical examination of the lower back revealed limited range. He could forward flex 30 degrees and extend 5 degrees. Right and left SLRs were both 80 degrees causing right-sided back pain that radiated in the right buttock and posterior thigh. He reported altered sensory loss to light touch and pinprick at the right lateral calf and bottom of his foot. He ambulated with a limp with the right lower extremity. Deep tendon reflexes were +1 at the knees and ankles. Toes were downgoing to plantar reflex bilaterally. He exhibited good 5/5 strength in the lower extremity muscle groups tested. According to a progress report dated 11/20/2014, the injured worker reported stabbing pain in his back that radiated down his leg. He reported a heavy, numb sensation and a burning component of pain. Pain was rated a 9 on a scale of 0-10 and at best was a 4 with medications. Pain was rated a 10 without medications. He reported left shoulder pain and neck pain that was rated a 6. With medications there was a 50 percent reduction in pain and 50 percent functional improvement with activities of daily living. Physical examination of the lower back revealed limited range. He could flex 30 degrees and extend 5 degrees. Right and left SLRs were both 80

degrees causing right-sided back pain. He reported altered sensory loss to light touch and pinprick in the right lateral calf and bottom of his foot. He ambulated with a limp. Deep tendon reflexes were +1 at the knees and ankles. Toes were downgoing to plantar reflex bilaterally. Palpation revealed muscle spasm in the lumbar trunk with loss of lordotic curvature. The provider's impression was noted as low back pain with radicular symptoms, MRI revealed a disc herniation at L4-L5 impinging on the right L5 nerve root, left shoulder decompression with myofascial pain persisting and left knee sprain/strain with chondromalacia patella and degenerative joint disease per imaging studies. Medications included Norco, ibuprofen and Flexeril. On 12/05/2014, Utilization Review non-certified Flexeril 10mg #45 that was requested on 11/25/2014. According to the Utilization Review physician, current evidence based guidelines recommend using Flexeril for the short-term treatment of acute exacerbations of low back pain. In review of the most recent evaluation, there was lack of evidence of an acute exacerbation of low back pain. Although the physical examination revealed muscle spasm, given the lack of an acute exacerbation, use of this medication is not indicated. CA MTUS Chronic Pain Treatment Guidelines, Muscle Relaxants were referenced for this review. The decision was appealed for an Independent Medical Review.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **1 prescription of Flexeril 10mg #45: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66.

**Decision rationale:** The patient presents with low back pain which radiates down his leg, left knee pain, and left shoulder pain. The request is for FLEXERIL 10 mg #45. In regards to the lower back, the patient has a limited range of motion, ambulates with a limp, palpation reveals muscle spasm in the lumbar trunk with loss of lordotic curvature, altered sensory loss to light touch, and pinprick in the right lateral calf and bottom of his foot. MTUS page 63-66 states: "muscle relaxants (for pain) recommended non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic LBP. The most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available) recommend for a short course of therapy." It is unknown when the patient began taking Flexeril. The 11/20/2014 report requests for a refill of Flexeril 10 mg, 1 q. 6 hours p.r.n. back spasms #45. MTUS Guidelines do not recommend use of cyclobenzaprine for longer than 2-3 weeks. Since the date the patient initially began taking Flexeril is not provided, he may have already exceeded the 2 to 3 weeks recommended by MTUS Guidelines. It is unknown if this medication is prescribed on a long-term basis. Therefore, the requested Flexeril IS NOT medically necessary.