

Case Number:	CM15-0172944		
Date Assigned:	09/15/2015	Date of Injury:	02/03/1987
Decision Date:	10/16/2015	UR Denial Date:	08/21/2015
Priority:	Standard	Application Received:	09/02/2015

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: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 injured worker is a 70-year-old male who sustained an industrial injury on 2/3/87. Injury occurred relative to a rear-end motor vehicle accident while working as a police officer. Conservative treatment included medications, physical therapy, activity modification, medications, and epidural steroid injection. The 5/1/15 lumbar spine MRI impression documented a small annular diffuse L4/5 disc bulge with advanced bilateral facet disease, ligamentum flavum redundancy, and congenital short pedicles, which caused severe central canal, lateral recess, and severe bilateral neuroforaminal stenosis with involvement of the bilateral exiting nerve roots. At L3/4, there was a foraminal disc osteophyte, left greater than right, and mild bilateral facet disease causing mild bilateral neuroforaminal stenosis. Osteophytes likely about the exiting left L3 nerve root. At L2/3, there was a stable 3 mm broad-based posterior disc protrusion with multiple moderate bilateral facet disease and ligamentum flavum redundancy and congenital short pedicles causing borderline central canal, mild lateral recess and bilateral neuroforaminal stenosis. At L1/2, there was a stable 3 mm broad-based posterior disc protrusion causing minimal bilateral neuroforaminal stenosis. At L5/S1, there was a tiny posterior central disc bulge with moderate bilateral facet disease which caused mild bilateral neuroforaminal stenosis. The 5/7/15 treating physician report cited low back pain radiating into the right lower extremity with poor balance. Symptoms were worse with flexion or extension, prolonged standing and sitting, and climbing stairs. Current medications included Gabapentin, Ranitidine, Tramadol ER, and Tizanidine. Physical exam documented slightly limited lumbar flexion and extension, normal lower extremity strength, intact sensation, and absent lower extremity deep tendon reflexes. He walked with a wide based steady gait and heel to toe gait was impossible. Surgery was recommended but the injured worker was not

interested at this time. Referral to a neurologist regarding balance issues was recommended. The 8/13/15 treating physician note indicated that the injured worker returned to discuss surgery. He had been referred to a neurologist for balance issues but had not yet been seen. He had moderately severe stenosis at L2/3 and severe stenosis at L4/5. His right leg was worse than his left. He was opined a good candidate for bilateral porthole type decompression at L2/3 and midline decompression at L4/5. Authorization was requested for inpatient L2-L5 decompression and associated surgical assistant, one day length of stay, pre-operative EKG, chest x-ray, and lab testing, lumbar support, Norco 10/325 mg #80, and Flexeril 10mg #75. The 8/21/15 utilization review certified requests for inpatient L2-L5 decompression and associated surgical assistant, one day length of stay, pre-operative EKG, chest x-ray, and lab testing, lumbar support, and Norco 10/325 mg #80. The request for Flexeril 10mg #75 was non-certified as there was no rationale to support the medical necessity of 75 doses of Flexeril.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexeril 10mg #75: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain), Cyclobenzaprine (Flexeril).

Decision rationale: The California MTUS guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic lower back pain. Flexeril is not recommended to be used for longer than 2 to 3 weeks. Guideline criteria have not been met. This injured worker has been certified for lumbar decompression surgery. Records indicate that the injured worker was currently prescribed another muscle relaxant. There is no current rationale submitted to support the medical necessity of post-op Flexeril at a quantity that exceeds guideline recommendations for use limited to 2 to 3 weeks or less. Therefore, this request is not medically necessary.