

<b>Case Number:</b>	CM15-0074638		
<b>Date Assigned:</b>	04/24/2015	<b>Date of Injury:</b>	05/23/2014
<b>Decision Date:</b>	06/09/2015	<b>UR Denial Date:</b>	04/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/20/2015

### 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: 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:

The injured worker is a 53 year old, male who sustained a work related injury on 5/23/14. He states his left arm was crushed by a forklift. He has a traumatic injury to left hand/wrist. The diagnoses have included severe soft tissue contusion of left hand and triangular fibrocartilage tear left wrist. The treatments have included physical therapy with electrical stimulation, chiropractic treatments, acupuncture and oral medications. In the Initial Orthopedic Evaluation Report dated 3/2/15, the injured worker complains of continuing, severe pain in left arm. He has tenderness and swelling about the left wrist/hand. He complains of pain with movement of left wrist/hand. There is point tenderness upon palpation of left wrist. The treatment plan includes a refill prescription for Flexeril.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flexeril 7.5mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63, 64.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants, pg 128.

**Decision rationale:** Guidelines do not recommend long-term use of this muscle relaxant for this chronic injury. Additionally, the efficacy in clinical trials has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. Submitted reports have not adequately demonstrated the indication or medical need for this treatment and there is no report of significant clinical findings, acute flare-up or new injury to support for its long-term use. There is no report of functional improvement resulting from its previous treatment to support further use as the patient remains unchanged. The Flexeril 7.5mg #90 is not medically necessary and appropriate.