

Case Number:	CM15-0091859		
Date Assigned:	05/18/2015	Date of Injury:	07/17/2014
Decision Date:	06/24/2015	UR Denial Date:	05/12/2015
Priority:	Standard	Application Received:	05/12/2015

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, Hawaii
 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 35-year-old male, who sustained an industrial injury on 07/17/2014. He has reported subsequent low back pain with radiation to the right lower extremity and was diagnosed with lumbar disc with radiculitis, degeneration of lumbar disc and post laminectomy syndrome of the lumbar region. Treatment to date has included oral and topical pain medication, lumbar epidural steroid injection, occupational therapy, physical therapy and surgery. In a progress note dated 05/05/2015, the injured worker complained of low back pain with radiation to the right lower extremity with numbness, tingling, weakness and bladder urgency. Objective findings were notable for an antalgic gait with limping on the right, major postural abnormalities, midline L4-S1 surgical incision that was healing well and restricted range of motion with guarding. A request for authorization of Cyclobenzaprine refill was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 7.5mg, #120 (Rx 05/05/15): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42.

Decision rationale: The patient presents with lower back pain with radiation to the right lower extremity. The current request is for Cyclobenzaprine 7.5mg, #120 (Rx 05/05/15). The treating physician has prescribed this medication since at least 2/2/15. The MTUS guidelines states that Flexeril is recommended as an option for a short course of therapy and treatment should be brief, not lasting for more than 2-3 weeks. In this case, the treating physician has continued to prescribe on a monthly basis a medication that is intended for short-term usage only per the MTUS guidelines. The current request is not medically necessary and the recommendation is for denial.