

Case Number:	CM13-0037517		
Date Assigned:	03/19/2014	Date of Injury:	04/16/2007
Decision Date:	05/07/2014	UR Denial Date:	10/10/2013
Priority:	Standard	Application Received:	10/23/2013

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 Occupational 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 expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records: The patient is a 53 year old male who was injured on 04/16/2007 while lifting bags of cement he apparently ruptured 3 discs. Prior treatment history has included the patient undergoing a posterior spinal fusion, L4-L5 and L5-S1 (bilateral infra-facet) on 09/10/2009 and bilateral exploration of spinal fusion with confirmation of arthrodesis (separately identifiable procedure) with bilateral removal of segmental DBR-II segmental pedicle screw/rod system, L4, L5 and S1. Medications include: 1. Gabapentin 300 mg 2. Cyclobenzaprine 10 mg 3. Cymbalta 30 mg 4. Oxycodone 10 mg 5. Methadone 10 mg Diagnostic studies reviewed include: MRI of the lumbar spine dated 06/05/2012 reveals: 1) There is focal cord signal abnormality in the ventral aspect of the distal thoracic cord to the right of midline. 2) At T11-12 a right paracentral disc protrusion is present. This causes at least mild central canal stenosis. 3) Status post discectomy and fusion from L4 through S1. Marow signal changes at L4, L5 and S1 presumably related to surgery and/or degenerative change. 4) At L2-3 disc bulge and facet arthropathy results in mild to moderate central canal stenosis. MRI of the thoracic spine w/o contrast dated 07/06/2012 reveals: 1) Multilevel degenerative changes of the thoracolumbar spine. 2) At T11-12, broad based disc bulge with superimposed left paracentral disc protrusion and annular tear as well as facet arthropathy and ligamentum flavum thickening associated with moderate spinal canal stenosis and flattening of the left hemicord and mild left foraminal narrowing. Cord signal abnormality seen at this level suggesting myelomalacia. 3) At T5-6 posterior disc/osteophyte complex with superimposed posterior central disc extrusion that causes indentation of the ventral cord and mild spinal canal stenosis. 4) Additional degenerative changes at T6-7 and T10-11. CT of the lumbar spine dated 12/18/2012 with the following results: 1) Prior anterior and posterior fusion, and posterior decompression from L4 through S1.

There is solid osseous fusion of the L4, L5 and S1 vertebral bodies and the hardware is intact. The right SI pedicle screw slightly encroaches on the right S1 lateral recess and neural foramen. 2) Mild spinal canal stenosis from inferior endplate of L2 through the superior endplate of L4 secondary to congenital narrowing. 3) At L4-L5 there is mild bilateral neural foraminal narrowing. 4) At L5-S1 there is moderate bilateral neural foraminal narrowing. AME dated 01/28/2013 documented conclusion: No contraindication to the performance of less invasive test such as MRI scan of the thoracic spine rather than a myelogram, which is an invasive test. PR-2 dated 10/04/2013 documented the patient to have complaints of having difficulty with his pain and functionality. He was given a prescription for a cane the last time to assist with ambulation but the proper authorization request was not submitted. So he never received it. He is also asking to increase his medications to provide better control for his pain. His pain level today in the back is 7/10 and typically it gets worse as the day goes on. Objective findings on exam revealed patient is using a cane and walks with a limp. He is very unsteady and moving with caution. The patient is able to sit for 15 minutes but demonstrates pain with frequent shifting in his seat and distributing his weight to his arms. He is able to comprehend and answer questions. Examination of the lumbar spine revealed restricted in all planes with increased pain. Very limited range of motion at approximately 15% of normal range. Muscle guarding is also noted in the thoracolumbar region. He has two vertical surgical incisions in the T11-12 region approximately 8 cm in length and paraspinous. Closed. Well healed scar appreciated, no heat, fluctuance or foul odor. Very tender to palpation.

IMR ISSUES, DECISIONS AND RATIONALES

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

CYCLOBENZAPRINE TAB 7.5MG 1-2 ORALLY BID #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-64.

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

Decision rationale: CA MTUS guidelines detail for Cyclobenzaprine (Flexeril®) "Recommended as an option, using a short course of therapy. See Medications for chronic pain for other preferred options. Cyclobenzaprine (Flexeril®) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001) Treatment should be brief. There is also a post-op use. The addition of cyclobenzaprine to other agents is not recommended. Cyclobenzaprine-treated patients with fibromyalgia were 3 times as likely to report overall improvement and to report moderate reductions in individual symptoms, particularly sleep. Note: Cyclobenzaprine is closely related to the tricyclic antidepressants, e.g., amitriptyline. See Antidepressants. Cyclobenzaprine is associated with a number needed to treat of 3 at 2 weeks for symptom improvement in LBP and is associated with drowsiness and dizziness. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system (CNS) depressant that is marketed as Flexeril by Ortho McNeil Pharmaceutical. This medication should be used for the short term. Limited evidence does not

allow for long term treatment in the guidelines cited above. Therefore, this should be discontinued without weaning. This is not medically necessary.

METHADONE TAB 10MG PO TID #180: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93.

Decision rationale: CA MTUS guidelines detail: "Methadone (Dolophine®®, Methadose®® oral dosage forms, generic available): Side Effects: See methadone adverse effects. Analgesic dose: For moderate to severe pain the initial oral dose (opioid naive) is 2.5mg to 10mg every 8 to 12 hours. However, a smaller dosing interval (every 4 to 12 hours) may be needed to produce adequate pain relief." The provider is well familiar with this patient and the use of methadone seems appropriate per the guidelines. The dose is suspect, but the primacy of the treating provider is paramount in my opinion for dosing. This is medically necessary.