

<b>Case Number:</b>	CM14-0127081		
<b>Date Assigned:</b>	08/13/2014	<b>Date of Injury:</b>	01/01/1980
<b>Decision Date:</b>	09/18/2014	<b>UR Denial Date:</b>	08/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/11/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 injured worker is a 69 year old male who had a work related injury on 01/01/80. Mechanism of injury was not documented. Most recent clinical documentation submitted for review was dated 06/25/14, the injured worker followed up with back pain. The injured worker was status post radiofrequency ablation. The injured worker reported 50% improvement following radiofrequency ablation. He still had low back pain described as sharp, pins and needles, stabbing pain. Current pain rating was 4/10, aggravating factors were standing, and alleviating factors were lying down and medication. Previous treatment was nerve blocks and injections. Current medication was Norco 7.5/325mg tablets one by mouth every 4-6 hours as needed for pain, Terazosin HCl 2mg caplets, Verapamil HCl ER 100mg simvastatin, and Omeprazole. Physical examination indicated well-nourished, well hydrated, and no acute distress. Neurological examination speech was fluent. Cognition was intact. Lumbar exam well healed midline incision. No tenderness in either sciatic notch. Straight leg raise was negative, reproduced back pain only both in the seat both on the right and left side. Gait was normal. Posture was hypolordotic. Strength was symmetric. Decreased light touch in the right lower extremity. Diagnosis spondylosis lumbar spine without myelopathy. Lumbar spine discogenic pain. Lumbar spine facet arthropathy. Chronic pain. Failed back surgery syndrome. Back pain. Prior utilization review on 08/05/14 was non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cyclobenzaprine HCL 10mg #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 41 OF 127.

**Decision rationale:** As noted on page 63 of the Chronic Pain Medical Treatment Guidelines, muscle relaxants are recommended as a second-line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Studies have shown that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Based on the clinical documentation, the patient has exceeded the 2-4 week window for acute management also indicating a lack of efficacy if being utilized for chronic flare-ups. As such, the medical necessity of this medication cannot be established at this time.

**Lumbar SCS (spinal cord stimulation) trial:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators Page(s): 105.

**Decision rationale:** The request for SCS trial is not medically necessary. The clinical documentation submitted for review does not support the request. There is no documentation of a psychological evaluation. The injured worker does not have any leg symptoms based on the most recent clinical record submitted for review. As such, medical necessity has not been established.