

Case Number:	CM14-0132493		
Date Assigned:	08/22/2014	Date of Injury:	11/10/2011
Decision Date:	10/01/2014	UR Denial Date:	07/29/2014
Priority:	Standard	Application Received:	08/19/2014

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 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 patient is a 57 year old female who was injured on 11/10/2011, while arresting a felon. She fell backwards, impacting the lumbar spine. She noted the immediate onset of lumbar pain. The patient underwent lumbar medial branch block radiofrequency ablation at Left L3, 4 on 06/03/2013. Progress report dated 07/11/2013 indicated that the patient had low back pain and rated her pain as 5/10. The back pain was a constant dull, achy, sharp-shooting and burning with pins and needles sensations. Cyclobenzaprine Hydrochloride 5 mg tablet 1-2 QHS as needed and Medrox #3 were listed under current medications. On examination, gait was non-antalgic and the patient was able to heel and toe walk. At her best posture, the patient did not demonstrate any major postural abnormalities or guarding. Range of motion of the lumbar spine was limited in flexion, extension, lateral rotation and lateral bending with no increase in concordant pain in all planes, especially ipsilateral pain along L4-5 facet with extension and lateral rotation. Muscle strength was 5/5 bilateral lower extremities. Sensation was normal to light touch, pinprick and temperature along all dermatomes bilateral lower extremities. Deep tendon reflexes (DTRs) were 2+ bilateral ankles and 2+ bilateral knees. Straight leg raise test was negative bilaterally for radicular signs until 60 degrees. The patient was diagnosed with facet arthropathy, syndrome, lumbar degenerative disk disease and low back pain. Medrox #3 QD for 30 days was refilled. The patient was advised to continue Cyclobenzaprine Hydrochloride 5mg 1-2 orally QHS. Diagnostic studies reviewed include MRI of the lumbar spine dated 03/22/2012 revealed mild disc bulge at L3-4 and L4-5 with facet arthropathy causing left foraminal impingement at L3-4, right greater than left NF impingement. Bilateral facet arthropathy and ligamentum flavum hypertrophy at L3-4 and L4-5. Progress report dated 07/22/2014 states the patient presented with complaints of low back pain. She stated the pain was worse and rated the pain as 5/10. The back pain was a constant dull, achy, sharp-shooting and burning with pins and needles

sensations. Cyclobenzaprine Hydrochloride 7.5 mg tablet 1-2 QHS as needed, Tylenol 325 mg tablet 2 tabs every 4 hrs and Medrox #3 QD were listed under current medications .On exam, there were no specific findings documented. Gait was non-antalgic and the patient was able to heel and toe walk. At her best posture, the patient did not demonstrate any major postural abnormalities or guarding. The patient was diagnosed with facet arthropathy, syndrome, lumbar degenerative disk disease and low back pain. The patient was recommended acupuncture, Medrox patch, and cyclobenzaprine hydrochloride.Prior utilization review dated 07/29/2014 states the request for Cyclobenzaprine Hydrochloride 7.5mg #45 is not approved as muscle relaxants are not recommended for long term use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine Hydrochloride 7.5mg #45: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines , Muscle Relaxant Page(s): 63-64.

Decision rationale: The Chronic Pain Medical Treatment Guidelines, MTUS (effective July 18, 2009) recommends Cyclobenzaprine for a short course of therapy. Limited, mixed -evidence does not allow for a recommendation for chronic use. This medication is not recommended to be used for longer than 2-3 weeks. Based on the review of the treatment records, the patient has been taking Cyclobenzaprine since 07/11/2013.The Chronic Pain Medical Treatment Guidelines, MTUS (effective July 18, 2009) recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (Van Tulder, 2003) (Van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in lower back pain (LBP) cases, they show no benefit beyond non-steroidal anti-inflammatory drugs (NSAIDs) in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. Drugs with the most limited published evidence in terms of clinical effectiveness include chlorzoxazone, methocarbamol, dantrolene and baclofen. (Chou, 2004) According to a recent review in American Family Physician, skeletal muscle relaxants are the most widely prescribed drug class for musculoskeletal conditions (18.5% of prescriptions), and the most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. (See2, 2008).Based on the Chronic Pain Medical Treatment Guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.