

Case Number:	CM15-0130879		
Date Assigned:	07/17/2015	Date of Injury:	03/08/2014
Decision Date:	09/10/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	07/07/2015

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: New York
 Certification(s)/Specialty: Internal Medicine

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 38 year old female, who sustained an industrial injury on March 8, 2014. She reported hearing a loud popping sound and in the right shoulder and pain of the right neck, right shoulder, and right arm. The injured worker was diagnosed as having cervical radiculopathy, herniated nucleus pulposus of the cervical spine, cervical stenosis, lumbar radiculopathy, and right shoulder arthralgia. Diagnostic studies to date have included: On August 19, 2014, an MRI of the right shoulder revealed a high-grade partial-thickness bursal surface thickness tear within the anterior leading edge superimposed on supraspinatus tendinosis. There was a slight irregularity of the posterior superior labrum. On October 20, 2014, electromyography/nerve conduction velocity studies of the bilateral upper and lower extremities were unremarkable. On December 19, 2014, an MRI of the cervical spine revealed a broad-based bulge and osteophyte ridge and central protrusion resulting in mild canal stenosis without neural foraminal narrowing at cervical 3-cervical 4. At cervical 4-cervical 5 and cervical 5-cervical 6, there was a broad-based bulge and osteophyte ridge and central protrusion resulting in mild to moderate canal stenosis with contact and distortion of the cervical cord, without neural foraminal narrowing. At cervical 6-cervical 7 and cervical 7-thoracic 1, there were small central protrusions without canal stenosis or neural foraminal narrowing. Surgeries to date include: right shoulder subacromial decompression and limited debridement on January 19, 2015. Treatment to date has included physical therapy for the shoulder, a right shoulder steroid injection, a home exercise program, work modifications, a sling, ice, and medications including opioid analgesic, topical analgesic, proton pump inhibitor, muscle relaxant, and non-steroidal

anti-inflammatory. There were no noted previous injuries or dates of injury or comorbid diagnoses. On May 13, 2015, the injured worker reported neck, low back, right upper and lower extremity complaints, which are worse since the last visit. She reported decreased pain and increased function of her right shoulder following surgery on January 19, 2015. She complained of continued pain and decreased range of motion of her right shoulder after postoperative physical therapy. She reported hearing a popping in her shoulder with certain movements. She complained of constant aching and burning pain of the neck, greater on the right than the left. Associated symptoms include increased pain and burning with numbness, tingling, and weakness down the right upper extremity to the three middle fingers; numbness and tingling in the left three middle fingers, and occasional dropping of objects due to right arm weakness. Her neck pain is rated 6/10. She complained of intermittent, intense, aching pain of the mid back, which was rated 7-8/10. She complained of increased aching low back pain, greater on the right than the left. Associated symptoms include increased and more frequent, radiating numbness and tingling down the right lower extremity to the three lateral toes. She complained of shooting pain radiating down her right lower extremity after sitting for long periods of time. Her pain is rated 7/10. The physical exam revealed a normal gait, normal heel and toe walk, decreased cervical range of motion, and decreased range of motion of the cervical, thoracic, and lumbar spines. There was tenderness to palpation of the cervical and lumbar spines extending into the right paraspinal region with spasms noted. There decreased sensation to the right cervical 5 through C8 dermatomes and of the right lumbar 3 through sacral 1 dermatomes with decreased motor strength in the right upper and lower extremity. The left biceps, left brachioradialis, and bilateral patella reflexes were hyperreflexive and the bilateral Achilles reflexes were hyporeflexive. There was decreased and painful range of motion of the left shoulder with an audible pop with abduction. The treatment plan includes Cyclobenzaprine 7.5mg as needed spasms. Her work status was temporarily partially disabled with limiting of standing, sitting, and walking to 30 minutes with a 10 minute break or change in position, limiting of lifting, pushing, and pulling to 10 pounds, and limiting kneeling, squatting, stooping, and bending to rare. The requested treatment is Cyclobenzaprine 7.5mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299, Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril); Muscle Relaxants (for pain) Page(s): 41; 63-66.

Decision rationale: Per the California Medical Treatment Utilization Schedule (CMTUS) guidelines, non-sedating muscle relaxants are recommended with caution as a "second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain". The combination of muscle relaxants with non-steroidal anti-inflammatory drugs has shown no additional benefit. The efficacy appears to diminish over time, and prolonged use of some

medications in this class may lead to dependence. The CMTUS guidelines recommend Cyclobenzaprine (Flexeril) for short-term treatment (no longer than 2-3 weeks) to decrease muscle spasms in the lower back. The ACOEM (American College of Occupational and Environmental Medicine) guidelines recommend muscle relaxants for the short-term treatment of acute spasms of the low back. The medical records show that the injured worker has been taking cyclobenzaprine as needed for low back spasms since at least December 2014, which significantly exceeds the short-term treatment recommended by the guidelines. Therefore, the cyclobenzaprine is not medically necessary.