

Case Number:	CM15-0132917		
Date Assigned:	07/21/2015	Date of Injury:	05/22/1997
Decision Date:	09/29/2015	UR Denial Date:	06/30/2015
Priority:	Standard	Application Received:	07/09/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 62 year old male, who sustained an industrial injury on May 22, 1997. He reported headaches due to work related stress. The injured worker was diagnosed as having moderate disc desiccation at cervical 5-cervical 6 and cervical 6-cervical 7 with 3 millimeter disc bulges and facet arthrosis causing moderate neuroforaminal stenosis bilaterally, per MRI dated December 3, 2014; moderate to severe disc desiccation at lumbar 3-lumbar 4 and mild at lumbar 4-lumbar 5. At lumbar 3-lumbar 4, there is a 5 millimeter right broad-based disc protrusion with moderate facet arthrosis causing moderate central canal stenosis and moderate to severe right-sided and moderate left-sided subarticular recess stenosis, as well as moderate neuroforaminal stenosis bilaterally, per MRI dated December 3, 2014; Partial thickness surface tear of the supraspinatus tendon without retraction. There is a sprain of the superior labrum at 12 o'clock versus a subtle tear and moderate acromioclavicular joint arthrosis with down sloping acromium, per MRI dated December 3, 2014; bilateral knee patellofemoral pain, mild osteoarthritis; bilateral knee meniscal tear status post arthroscopy, resolved; and mild right compression of the median nerve at the carpal tunnel, per electrodiagnostic studies criteria dated January 18, 2015. Treatment to date has included viscosupplementation injections, a right wrist brace, a left knee steroid injection, physical therapy, and medications including opioid analgesic, topical analgesic, and non-steroidal anti-inflammatory. Other noted dates of injury documented in the medical record include: January 29, 2000, November 27, 2001, January 1, 1982 to October 17, 2002, August 17, 2000 to August 18, 2001 and October 17, 2002. Comorbid diagnoses included history of hypertension and hyperlipidemia. On June 11, 2015, the injured worker complained of

persistent, constant neck and lower back pain, which is about the same since the prior visit. His neck radiated to both arms and his lower back pain radiated to the bilateral lower extremities. He complained of intermittent right shoulder pain that radiated to the right upper extremity, which was unchanged. He complained of bilateral wrist pain that radiated to the first and third digits. He complained of constant and worsening bilateral knee pain, right worse than left that radiated to the calf with more grinding. He reported the viscosupplementation injection series provided temporary relief for a month or so, but the pain is now returning and worsening. He complained of intermittent right ankle pain, which is unchanged. Rest and analgesic medication helps the pain. The physical exam revealed decreased cervical range of motion due to pain, which was more severe with right lateral rotation. There was a positive right Spurling's, tenderness to the paraspinal muscles, hypertonicity of the bilateral trapezius muscles, a positive cervical compression test, and slight decreased sensation in the right cervical 5 through cervical 7. There was tenderness of the lumbar paraspinal muscles, a positive Kemp's sign, a positive right straight leg raise at 50 degrees to the posterior thigh, slight decreased sensation at the right lumbar 4 and lumbar 5, and normal deep tendon reflexes in the patellar and Achilles tendons. There was slight decreased range of motion of the right shoulder, tenderness over the acromioclavicular joint, and positive Hawkins' and Neer's impingement tests. There were well-healed scars over the volar aspects at the bases of both wrists, slight decreased sensation on the right cervical 5 through cervical 7, and slight weak right grip. There was decreased range of motion of the bilateral knees, positive patellofemoral grind bilaterally, tenderness of the medial and lateral joint lines, and normal strength with flexion and extension bilaterally. There was normal range of motion and normal strength with plantar flexion and dorsiflexion of the bilateral ankles. Work stat us: Retired. The treatment plan includes Flexeril 10mg for spasms.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexeril 10 mg Qty 60 (retrospective dispensed 6/25/15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain); Flexeril (cyclobenzaprine).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299, Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-64.

Decision rationale: With regard to muscle relaxants, the MTUS CPMTG states: "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 most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement." Regarding Cyclobenzaprine: "Recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant with similar effects to tricyclic antidepressants (e.g. amitriptyline). Cyclobenzaprine is more effective than placebo in the management of back pain, although the effect is modest and comes at the price of adverse effects." Per p41 of the MTUS

guidelines the effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment is recommended for the treatment of acute spasm limited to a maximum of 2-3 weeks. With regard to medication history, the medical records do not indicate how long the injured worker has been using this medication. Per progress report dated 6/11/15, it was noted that the injured worker returned with persistent pain in the neck and lower back. Neck pain radiated to the bilateral arms while the lower back pain radiated to the bilateral lower extremities. Per physical exam, there were no findings of spasm noted. The patient is not being treated for an acute exacerbation of chronic back pain, so the requested treatment is not medically necessary.