

<b>Case Number:</b>	CM15-0192613		
<b>Date Assigned:</b>	10/06/2015	<b>Date of Injury:</b>	10/29/2014
<b>Decision Date:</b>	11/13/2015	<b>UR Denial Date:</b>	08/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/30/2015

### 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

Certification(s)/Specialty: Emergency 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 59 year old male who sustained an industrial injury on 10-29-2014. Medical records indicated the worker was treated for pain in the lumbar spine, a left hernia, and an umbilical hernia. In the provider notes of 08-09-2015, the worker presents with complaint that his symptoms have worsened. The worker states he has been taking Norco for a long time and has not experienced noticeable change and would like to discuss the possibility of changing to Percocet, which provided significant relief in the past. The injured worker complains of a constant burning and grinding pain across his low back that he rates at an 8 on a scale of 0-10 at the time of evaluation. He denies any radicular symptoms. But reports a constant pressure and pins and needles in the lower back. The pain is aggravated by prolonged sitting, rising from a seated position, prolonged standing or walking, and lying on his back. He states he has occasional spasms in the back. On physical exam, he has a mildly antalgic gait. He has bilateral lumbar paraspinal tenderness with spasms. The lumbar spine is tender to palpation at midline, and he has pain with bilateral lumbar facet loading. Bilateral lumbar facets are tender to palpation. Neurologically, the worker has decreased sensation in the right L5 and S1 dermatomes to pinprick, and his motor exam shows 5- out of five on the bilateral psoas, quads, hamstrings; Motor exam was limited only by pain. He has normal patellar reflex bilaterally, decreased Achilles reflex bilaterally, and straight leg raise on the right positive at 40 degrees and on the left he has a negative straight leg raise test. An electromyogram done 05-04-2014 was abnormal suggesting a S1 root involvement and was suggestive of a bilateral S1 radiculopathy. MRI films and report of the lumbar spine on 06-26-2015 gave the impressions of degenerative

disc disease and facet arthropathy with retrolisthesis L2-3, L3-4 and grade 1 anterolisthesis L4-5 and L5-S1 with possible L5 spondylolisthesis and with L4 and L5 pedicle-posterior element edema-stress reaction. It also showed L4-5 mild canal stenosis, neural foraminal narrowing L1-2 and L2-3 caudal left; L4=5 moderate right, mild to moderate left neural foraminal narrowing. There was a L5-S1 central protrusion-extrusion slightly contracting the S1 nerve root. Current medications included Gabapentin which helped decrease numbness and tingling in his right lower extremity by 50%, Norco 3 tablets daily that gave no relief but helped improved sleep, and Flexeril that helped with sleep and decreased his muscle spasms (note of 08-19-2015). A request for authorization was submitted for: 1. Transforaminal epidural steroid injection, right L4-5. 2. Transforaminal epidural steroid injection, right L5-S1. 3. Transforaminal epidural steroid injection, right S2-2 foramen. 4. Gabapentin 600mg, #90. 5. Cyclobenzaprine 7.5mg, #60. 6. Norco 10/325mg, #60. A utilization review decision 08-28-2015 authorized the requests for the Transforaminal epidural steroid injections, the Gabapentin, and the Norco, and denied the request for denied the request for Cyclobenzaprine 7.5mg, #60

### **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 Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**Decision rationale:** The requested Cyclobenzaprine 7.5mg, #60, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Muscle Relaxants, page 63-66, do not recommend muscle relaxants as more efficacious than NSAIDs and do not recommend use of muscle relaxants beyond the acute phase of treatment. The injured worker has occasional spasms in the back. On physical exam, he has a mildly antalgic gait. He has bilateral lumbar paraspinal tenderness with spasms. The lumbar spine is tender to palpation at midline, and he has pain with bilateral lumbar facet loading. Bilateral lumbar facets are tender to palpation. Neurologically, the worker has decreased sensation in the right L5 and S1 dermatomes to pinprick, and his motor exam shows 5- out of five on the bilateral psoas, quads, hamstrings; Motor exam was limited only by pain. The treating physician has not documented duration of treatment, intolerance to NSAID treatment, or objective evidence of derived functional improvement from its previous use. The criteria noted above not having been met, Cyclobenzaprine 7.5mg, #60 is not medically necessary.