

Case Number:	CM15-0193365		
Date Assigned:	10/07/2015	Date of Injury:	01/26/2015
Decision Date:	11/13/2015	UR Denial Date:	09/11/2015
Priority:	Standard	Application Received:	10/01/2015

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, Indiana, 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 30 year old male, who sustained an industrial injury on January 26, 2015. The injured worker was diagnosed as having cervical strain. Treatment and diagnostic studies to date has included magnetic resonance imaging of the cervical spine, physical therapy, and medication regimen. In a progress note dated September 04, 2015 the treating physician reports complaints of "moderate", intermittent, achy, throbbing, burning, and cramping pain to the low back along with muscle tightness, pain to the upper back and neck muscle, bilateral arm and thigh spasms, and pain that radiates to the bilateral shoulders. Examination performed on September 04, 2015 was revealing for guarding to the cervical spine nuchal region, mild swelling and guarding to the cervical paraspinal muscles, "moderate" tenderness to the cervical paraspinal muscles, spasm to the cervical paraspinal muscles, twitching to the cervical paraspinal muscles, decreased sensation with numbness to the lower cervical spine, numbness and tingling to the bilateral arms with the right greater than the left, positive bilateral axial compression testing, pain with range of motion to the cervical spine, tenderness to the lumbar paraspinal muscles, muscle spasm to the lumbar paraspinal muscles, and pain with range of motion to the lumbar spine. The injured worker's medication regimen on September 04, 2015 included Naproxen Sodium (since at least April of 2015), Cyclobenzaprine HCl (since at least September of 2015), and Ultram (since at least April of 2015), but the progress note did not indicate the injured worker's pain level as rated on a pain scale prior to use of his medication regimen and after use of his medication regimen to indicate the effects with the use of the injured worker's medication regimen. Also, the documentation provided did not indicate if the injured worker

experienced any functional improvement with use of his medication regimen. The progress note from September 04, 2015 noted magnetic resonance imaging report of the cervical spine performed on May 24, 2015 that was revealing for "moderately severe cervical spasm, otherwise negative study". On September 04, 2015 the treating physician requested epidural steroid injections at cervical six to seven and cervical seven to thoracic one noting "decreased pain to touch sensation send on dermatome. Based on that there appears that compression is somewhere and has been compression in the nerve root and probably inflammation around the nerve and therefore likely compression of the cervical seven nerve root at some time." The treating physician further noted "By doing cervical six to seven and cervical seven to thoracic one, I get above and below of the cervical seven nerve root exit hopefully to relief of his pain and get less spasm to get him back to functional capacity." The treating physician also requested Cyclobenzaprine HCL 10mg with a quantity of 30 noting current use of this medication for muscle spasms. On September 11, 2015 the Utilization Review determined the requests for Cyclobenzaprine HCL 10mg with a quantity of 30 for the date of service of September 04, 2015 and epidural steroid injections at cervical six to seven and cervical seven to thoracic one to be non-approved.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Cyclobenzaprine HCL 10mg #30 (DOS: 9/4/15): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Muscle relaxants.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, retrospective request cyclobenzaprine HCL 10mg #30 date of service September 4, 2015 is not medically necessary. Muscle relaxants are recommended as a second line option short-term (less than two weeks) of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Efficacy appears to diminish over time and prolonged use may lead to dependence. In this case, the injured worker's working diagnoses are cervical strain. Date of injury is January 26, 2015. Request for authorization is September 4, 2015. According to a September 4, 2015 progress note, subjective complaints include upper back pain and lower back pain. There are no subjective complaints referable to the neck. The injured worker completed physical therapy 18 sessions. Objectively, there is tenderness to palpation cervical spine spasm and trigger points. The neurologic evaluation did not show any focal deficits. There was no evidence of radiculopathy objectively. Cyclobenzaprine appears for the first time in the September 4, 2015 progress. A pain management progress note dated August 4, 2015 indicates a muscle relaxant was prescribed. The treating provider does not specify the muscle relaxant by name. Start date for cyclobenzaprine is not specified. Objectively, there is no lumbar spine spasm. There was no documentation of acute low back pain or an exacerbation of chronic low back pain in the medical record. The duration of use is not specified in the medical record. There is no

documentation demonstrating objective optional improvement to support ongoing cyclobenzaprine. As noted above, at a minimum, the treating providers prescribed a muscle relaxant as far back as August 4, 2015, however the start date is not specified. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, no documentation of acute low back pain or an exacerbation of chronic low back pain, no documentation demonstrating objective functional improvement to support ongoing cyclobenzaprine and documentation that indicates the treating provider exceeded the recommended guidelines for short-term use, retrospective request cyclobenzaprine HCL 10mg #30 date of service September 4, 2015 is not medically necessary.

ESI at C6-C7 & C7-T1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, Epidural steroid injections (ESIs).

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, epidural steroid injection at C6-C7 and C7-T-1 are not medically necessary. Cervical epidural steroid injections are not recommended based on recent evidence given the serious risks of the procedure in the cervical region and the lack of quality evidence for sustained benefit. Cervical ESI may be supported with the following criteria. Epidural steroid injections are recommended as an option for treatment of radicular pain. The criteria are enumerated in the Official Disability Guidelines. The criteria includes, but are not limited to, radiculopathy must be documented by physical examination and corroborated by imaging studies and or electrodiagnostic testing; initially unresponsive to conservative treatment (exercises, physical methods, nonsteroidal anti-inflammatory's and muscle relaxants); in the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks, etc. Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications and functional response. etc. See the guidelines for details. In this case, the injured worker's working diagnoses are cervical strain. Date of injury is January 26, 2015. Request for authorization is September 4, 2015. According to a September 4, 2015 progress note, subjective complaints include upper back pain and lower back pain. There are no subjective complaints referable to the neck. The injured worker completed physical therapy 18 sessions. Objectively, there is tenderness to palpation cervical spine spasm and trigger points. The neurologic evaluation did not show any focal deficits. There was no evidence of radiculopathy objectively. An MRI of the lumbar spine showed severe cervical spasm. There was no evidence of herniated disc or spinal stenosis. There were no electrodiagnostic studies in the record. There was no corroborating evidence indicating the presence of radiculopathy. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, no objective evidence of radiculopathy on physical examination and no corroborating evidence of radiculopathy with magnetic resonance imaging or electrodiagnostic studies, epidural steroid injection at C6-C7 and C7-T-1 are not medically necessary.