

<b>Case Number:</b>	CM15-0018679		
<b>Date Assigned:</b>	02/06/2015	<b>Date of Injury:</b>	05/10/2013
<b>Decision Date:</b>	03/30/2015	<b>UR Denial Date:</b>	01/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/02/2015

### 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: 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 56-year-old male who sustained an industrial lifting injury to his left shoulder, right knee and lower back on May 10, 2013. The injured worker was diagnosed with lumbar radiculitis, L2-3 disc protrusion with possible L2 nerve root impingement, moderate L4-5 facet degenerative disease (MRI report dated 12/27/2013), SLAP tear and tendinosis of the bicep tendon and moderate acromioclavicular joint disease (MRI report dated 12/27/2013), extensive degenerative tearing of the medial meniscus with chondromalacia and chondral fissuring on the medial femoral condyle and tibial plateaus (MRI report dated 12/27/2013). According to the primary treating physician's progress report on December 8, 2104 the injured worker continues to experience pain and muscle weakness in the lower extremities with decreased sensation over the left anterior thigh. The injured worker underwent physical therapy, chiropractic therapy, injections to the left shoulder, bilateral knees and a transforaminal epidural steroid injection (ESI) at L2 and L3, left side in April 2014. Current medications consist of Tylenol #3, Tramadol, Lunesta, Fenoprofen, Nabumetone, Omeprazole and Colace. The injured worker is on temporary total disability (TTD) with modified work. The treating physician requested authorization for Cyclobenzaprine 7.5mg #30; Right Knee Ortho Consult; Left Sided L4-5 and L5-S1 Medial Branch Block. On January 19, 2015 the Utilization Review denied certification for Cyclobenzaprine 7.5mg #30; Left Sided L4-5 and L5-S1 Medial Branch Block. The Utilization Review modified the certification for Right Knee Ortho Consult to Certify Office Visit (follow up visit). Citations used in the decision process were the Medical Treatment Utilization Schedule

(MTUS), Chronic Pain Guidelines, American College of Occupational and Environmental Medicine (ACOEM) and the Official Disability Guidelines (ODG).

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Cyclobenzaprine 7.5mg #30: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, 49, Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Pages 41-42. Muscle relaxants Pages 63-66.. Decision based on Non-MTUS Citation FDA Prescribing Information Flexeril Cyclobenzaprine <http://www.drugs.com/pro/flexeril.html>

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) addresses muscle relaxants. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) states that muscle relaxants seem no more effective than NSAIDs for treating patients with musculoskeletal problems, and using them in combination with NSAIDs has no demonstrated benefit. Muscle relaxants may hinder return to function by reducing the patient's motivation or ability to increase activity. Table 3-1 states that muscle relaxants are not recommended. Chronic Pain Medical Treatment Guidelines addresses muscle relaxants. Muscle relaxants should be used with caution as a second-line option for short-term treatment. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. According to a review in American Family Physician, muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Chronic Pain Medical Treatment Guidelines state that Cyclobenzaprine (Flexeril) is an option for a short course of therapy. Treatment should be brief. The addition of Cyclobenzaprine to other agents is not recommended. FDA guidelines state that Cyclobenzaprine is indicated for acute musculoskeletal conditions. Cyclobenzaprine should be used only for short periods (up to two or three weeks) because adequate evidence of effectiveness for more prolonged use is not available. Medical records document that the patient's occupational injuries are chronic. MTUS, ACOEM, and FDA guidelines do not support the use of Cyclobenzaprine (Flexeril) for chronic conditions. Medical records indicate the long-term use of muscle relaxants, which is not supported by MTUS and FDA guidelines. The patient has been prescribed NSAIDs. Per MTUS, using muscle relaxants in combination with NSAIDs has no demonstrated benefit. The use of Flexeril is not supported by MTUS and ACOEM guidelines. Therefore, the request for Flexeril is not medically necessary.

#### **Right Knee Ortho Consult: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM for Independent Medical Examination and Consultation, chapter 7, page 127. Official Disability Guidelines, Knee and Leg chapter, Office Visits.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 75. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 7 Independent Medical Examiner Page 127

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) addresses occupational physicians and other health professionals. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 5 Cornerstones of Disability Prevention and Management (Page 75) states that occupational physicians and other health professionals who treat work-related injuries and illness can make an important contribution to the appropriate management of work-related symptoms, illnesses, or injuries by managing disability and time lost from work as well as medical care. ACOEM Chapter 7 Independent Medical Examiner (Page 127) states that the health practitioner may refer to other specialists when the plan or course of care may benefit from additional expertise. The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss, or fitness for return to work. A consultant may act in an advisory capacity, or may take full responsibility for investigation and treatment of a patient. The right knee MRI magnetic resonance imaging 12/27/13 demonstrated extensive degenerative tearing of the medial meniscus. There is associated medial compartment chondromalacia with grade 2/3 chondral fissuring on the medial femoral condyle and tibial plateau, and localized lateral tibial chondromalacia. Medical records document significant knee pathology that would benefit from the expertise of an orthopedic surgeon. The request for specialty referral and consultation is supported by MTUS and ACOEM guidelines. Therefore, the request for orthopedic consultation is medically necessary.

**Left Sided L4-5 And L5-S1 Medial Branch Block:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301, 308-310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) Facet joint intra-articular injections (therapeutic blocks), Facet joint medial branch blocks (therapeutic injections). ACOEM 3rd Edition. Low back disorders. Hegmann KT, editor(s). Occupational medicine practice guidelines. Evaluation and management of common health problems and functional recovery in workers. 3rd ed. Elk Grove Village (IL): American College of Occupational and Environmental Medicine (ACOEM); 2011. p. 333-796. Table 2: Summary of Recommendations by Low Back Disorder <http://www.guideline.gov/content.aspx?id=38438>

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) facet-joint injections for low back conditions. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints (page 300) states that invasive

techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Table 12-8 Summary of Recommendations for Evaluating and Managing Low Back Complaints (page 309) states that facet-joint injections are not recommended. Official Disability Guidelines (ODG) indicate that regarding facet joint intra-articular injections for low back disorders, no more than 2 joint levels may be blocked at any one time. Per ODG, facet joint medial branch blocks (therapeutic injections) are not recommended except as a diagnostic tool. Minimal evidence for treatment. ACOEM 3rd Edition (2011) states that diagnostic facet joint injections and therapeutic facet joint injections are not recommended for low back disorders. Medical records document low back complaints. ACOEM 2nd Edition (2004) indicates that facet-joint injections are not recommended. Per ODG, facet joint medial branch blocks (therapeutic injections) are not recommended except as a diagnostic tool. Minimal evidence for treatment was noted. ACOEM 3rd Edition (2011) states that that diagnostic facet joint injections and therapeutic facet joint injections are not recommended for low back disorders. The request for medial branch block is not supported by MTUS, ACOEM, or ODG guidelines. Therefore, the request for L4-5 and L5-S1 medial branch block is not medically necessary.