

Case Number:	CM15-0111910		
Date Assigned:	06/18/2015	Date of Injury:	08/27/2011
Decision Date:	07/20/2015	UR Denial Date:	05/13/2015
Priority:	Standard	Application Received:	06/10/2015

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 Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 49 year old male with a date of injury of 8/27/11. Diagnoses include Cervical Spondylosis, protrusion C2-C7, Acromioclavicular osteoarthropathy left shoulder pain, Superior labrum anterior to posterior lesion left shoulder, Tear supraspinatus left shoulder and partial tear infraspinatus, Status post left shoulder arthroscopy/rotator cuff repair, Acromioclavicular osteoarthropathy right shoulder, Tendonosis infraspinatus and supraspinatus, right shoulder, Bialteral carpal tunnel syndrome, Bilateral trigger thumb, Myofascial low back pain, Lumbar radiculopathy- electrodiagnostically positive S1, Cervical pain with upper extremity symptoms, and Thoracic pain. A primary treating physician report dated 4/14/15 notes subjective complaints of cervical pain as 7/10 with left greater than right upper extremity symptoms, 6/10 thoracic pain, 6/10 low back pain with lower extremity symptoms, left shoulder pain 8/10, right shoulder pain 5/10, status post bilateral carpal tunnel release, 5/10 right wrist/hand pain and 5/10 left wrist/hand pain. There is prior history of a successful trial of topical non-steroidal anti-inflammatory drugs, that they did facilitate up to a 5 point diminution in cervical, thoracic, and lumbar spine pain with improved range of motion and 30% improved tolerance to standing and walking. The oral non-steroidal anti-inflammatory drugs failed due to gastrointestinal side effects even with proton pump inhibitor medication. Medications include Cyclobenzaprine 7.5 mg three times a day and Hydrocodone 10 mg twice a day. Objective findings are tenderness of the cervical spine with range of motion on flexion of 40 degrees, extension of 30 degrees, left and right lateral tilt 30 degrees left and right rotation 30 degrees. There is diminished sensation on the left greater than right L4, L5, and S1 dermatomal distribution.

There is a positive straight leg raise bilaterally for pain to foot at 40 degrees. Tenderness of the right shoulder is noted with positive impingement signs and a positive Jobe test. Bilateral wrists were positive for Tinel's sign /Phalens's maneuver. The left shoulder continues to worsen with decline in activity/function. The electromyography and nerve conduction velocity of the lower extremities on 3/23/15 demonstrates right S1 radiculopathy. A urine drug screen report dated 2/5/15 was consistent with prescribed medication for Hydrocodone, Hydromorphone, Tramadol, and inconsistent with prescribed medication for Gabapentin and Cyclobenzaprine. The treatment plan is for a psychiatric consult for with follow up to discuss reactive depression, MRI of the left shoulder, therapeutic epidural injection to the lumbar spine, chiropractic treatment 3 times a week for 4 weeks, acupuncture 2 times a week for 6 weeks, Cyclobenzaprine and Hydrocodone-with anticipation of significant taper on follow up, and Ketaprofen 10% in base/300 grams. The requested treatment is Cyclobenzaprine 7.5 mg quantity 90, 1 three times daily as needed for spasm.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 7.5 mg Qty 90, 1 three times daily as needed for spasm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: According to MTUS guidelines, Cyclobenzaprine a non sedating muscle relaxants is recommended with caution as a second line option for short term treatment of acute exacerbation in patients with chronic spasm and pain. Efficacy appears to diminish over time and prolonged use may cause dependence. The guidelines do not recommend to be used form more than 2-3 weeks. The patient in this case does not have recent evidence of spasm and the prolonged use of Cyclobenzaprine is not justified. Therefore, the request for Cyclobenzaprine 7.5mg #90 is not medically necessary.