

Case Number:	CM15-0075256		
Date Assigned:	04/27/2015	Date of Injury:	09/09/2013
Decision Date:	07/02/2015	UR Denial Date:	04/14/2015
Priority:	Standard	Application Received:	04/20/2015

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 42 year old female, who sustained an industrial injury on September 9, 2013. The injured worker was diagnosed as having 2mm protrusion at L4-L5 with left neutral encroachment, rule out cervical radiculopathy, thoracic myofascial pain, and right foot plantar fasciitis. Treatment to date has included TENS, MRIs, and medication. Currently, the injured worker complains of low back pain with left greater than right lower extremity symptoms, thoracic pain, cervical pain with increasing upper extremity symptoms, and right foot pain. The Primary Treating Physician's report dated March 13, 2015, noted the injured worker reported nausea with the Tramadol. Physical examination was noted to show lumbar spine tenderness with positive bilateral straight leg raise. Thoracic spine tenderness with spasm of the thoracic musculature and spasms in the lumboparaspinal musculature was noted, with tenderness in the right plantar foot/heel and the left plantar foot/heel. The treatment plan was noted to include requests for physical therapy for the lumbar spine and right foot, and a MRI of the cervical spine, with medications dispensed including Duloxetine, Naproxen Sodium, Pantoprazole, and Cyclobenzaprine.

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: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) page(s): 63-65. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain chapter - non-sedating muscle relaxants.

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 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. The primary treating physician report dated 3/13/15 documented subjective complaints of low back pain with lower extremity symptoms, thoracic pain, cervical pain with upper extremity symptoms, and right foot pain. Medical records document that the patient's occupational injuries are chronic. The date of injury was 9/29/13. The primary treating physician report dated 3/13/15 documented the prescription of Cyclobenzaprine (Flexeril). The primary treating physician report dated 2/20/15 documented the prescription of Cyclobenzaprine (Flexeril). Medical records document the long-term use of the muscle relaxant Cyclobenzaprine (Flexeril). 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. Medical records document the use of NSAIDs. Per MTUS, using muscle relaxants in combination with NSAIDs has no demonstrated benefit. The use of Cyclobenzaprine (Flexeril) is not supported by MTUS or ACOEM guidelines. Therefore, the request for Cyclobenzaprine (Flexeril) is not medically necessary.

MRI (magnetic resonance imaging), C - (cervical) Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints page(s): 179-180. Decision based on Non-MTUS Citation Official Disability Guidelines: Neck & Upper Back chapter - Indications for imaging.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints page(s): 177-179, 181-183.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses cervical spine MRI magnetic resonance imaging. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints indicates that reliance on imaging studies alone to evaluate the source of neck or upper back symptoms carries a significant risk of diagnostic confusion (false-positive test results). Table 8-8 Summary of Recommendations for Evaluating and Managing Neck and Upper Back Complaints (page 181-183) indicates that radiography are the initial studies when red flags for fracture, or neurologic deficit associated with acute trauma, tumor, or infection are present. MRI may be recommended to evaluate red-flag diagnoses. Imaging is not recommended in the absence of red flags. MRI may be recommended to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. The primary treating physician report dated 03/13/2015 documented subjective complaints of cervical pain with upper extremity symptoms. The date of injury was 9/29/13. Physical examination demonstrated tenderness of the thoracic spine and spasm of the thoracic musculature. Cervical range of motion was flexion 40 degrees, extension 25 degrees, rotation 25 degrees. No neurologic deficits were documented. No X-ray plain film radiograph results were documented. No objective evidence of a red flag was noted. ACOEM indicates that imaging is not recommended in the absence of red flags. The request for cervical spine MRI is not supported. Therefore, the request for MRI of the cervical spine is not medically necessary.

Physical Therapy, 3 times weekly for 4 weeks, Right Foot: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM page(s): 114. Decision based on Non-MTUS Citation Official Disability Guidelines: Ankle & Foot chapter - Physical Therapy Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy (PT) Physical Medicine pages 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Physical medicine treatment. ODG Preface Physical Therapy Guidelines. ODG Ankle & Foot (Acute & Chronic) Physical therapy (PT).

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines provide physical therapy (PT) physical medicine guidelines. For myalgia and myositis, 9-10 visits are recommended. For neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. Official Disability Guidelines (ODG) present physical therapy PT guidelines. Patients should be formally assessed after a six visit clinical trial to evaluate whether PT has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. Per Medical Treatment Utilization Schedule (MTUS) definitions, functional improvement means either a clinically significant improvement

in activities of daily living or a reduction in work restrictions, and a reduction in the dependency on continued medical treatment. Magnetic resonance imaging MRI of the right foot dated 2/20/15 demonstrated mild to moderate plantar fasciitis, with no other significant findings. The primary treating physician report dated 03/13/2015 documented subjective complaints of right foot pain. The date of injury was 9/29/13. Physical examination demonstrated tenderness of bilateral plantar foot/heel. The diagnosis was right foot plantar fasciitis. Physical therapy for the right foot three times a week for four weeks (12) was requested. No functional improvement with past physical therapy visits was documented. Official Disability Guidelines (ODG) recommends 6 PT visits for plantar fasciitis. The request for 12 physical therapy visits exceeds MTUS guidelines, and is not supported. Therefore, the request for physical therapy (12) for the right foot is not medically necessary.

Physical Therapy, 3 times weekly for 4 weeks, Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 114. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back chapter - Physical Therapy Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy (PT) Physical Medicine pages 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Physical medicine treatment. ODG Preface Physical Therapy Guidelines. ODG Low Back (Acute & Chronic) Physical therapy (PT).

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines provide physical therapy (PT) physical medicine guidelines. For myalgia and myositis, 9-10 visits are recommended. For neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. Per Medical Treatment Utilization Schedule (MTUS) definitions, functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions, and a reduction in the dependency on continued medical treatment. The primary treating physician report dated 03/13/2015 documented subjective complaints of low back pain with lower extremity symptoms, thoracic pain, and cervical pain with upper extremity symptoms. The date of injury was 9/29/13. Physical examination demonstrated tenderness of lumbar spine. Lumbar range of motion was flexion 40 degrees, extension 35 degrees, lateral tilt 35 degrees, rotation 35 degrees. Positive straight leg raise bilaterally was noted. Tenderness thoracic spine and spasm of the thoracic musculature was noted. Spasm of lumboparaspinal musculature was noted. Physical therapy for the lumbar spine three times a week for four weeks (12) was requested. No functional improvement with past physical therapy visits was documented. Official Disability Guidelines (ODG) recommends 9 PT visits for lumbago. Official Disability Guidelines (ODG) present physical therapy PT guidelines. Patients should be formally assessed after a six visit clinical trial to evaluate whether PT has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. The request for 12 physical therapy visits

exceeds MTUS guidelines, and is not supported. Therefore, the request for physical therapy (12) for the lumbar spine is not medically necessary.