

Case Number:	CM15-0092513		
Date Assigned:	05/18/2015	Date of Injury:	04/29/2005
Decision Date:	06/22/2015	UR Denial Date:	04/17/2015
Priority:	Standard	Application Received:	05/13/2015

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: Physical Medicine & Rehabilitation

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 67-year-old female who sustained an industrial injury on 4/29/05 when she slipped and fell striking her head. She was medically evaluated and received physical therapy, acupuncture, intermittent hydrocodone, anti-inflammatory medication and muscle relaxants. She had an MRI of the lumbar spine (1/06) showing degenerative changes with borderline spinal stenosis, focal disc bulging and facet arthropathy. She was diagnosed with cervicolumbar spondylosis and chronic pain syndrome. She currently complains of neck pain, low back and bilateral lower extremity pain, numbness and tingling. On physical exam of the lumbar spine there was good range of motion, spasm and guarding at the base. Straight leg raise test is negative. Medications are Tylenol, hydrocodone, Disalcid. Diagnoses include probable lumbar spinal stenosis with resulting neurogenic claudication; lumbar disc displacement without myelopathy; lumbago; neck pain; lumbosacral sprain/ strain. In the progress note dated 4/1/15 the treating provider's plan of care includes requests for MRI of the lumbar spine as the last one was in 2006 showing borderline spinal stenosis which has probably progressed as the injured worker has increased symptoms. The treating provider felt that he needed an understanding of the underlying anatomical pathology in the lumbar spine. A request for a trial of Flexeril 7.5 mg was also recommended as the injured worker has spasms that disturb her sleep.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Lower Back, MRI.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back Chapter, MRI.

Decision rationale: The patient presents on 04/01/15 with neck pain, and unrated lower back pain which radiates into the bilateral lower extremities, and associated numbness and tingling in the bilateral lower extremities. The patient's date of injury is 04/29/05. Patient has no documented surgical history directed at these complaints. The request is for MRI of the lumbar spine. The RFA is dated 04/07/15. Physical examination dated 04/01/15 reveals flattened lumbar lordosis, spasms and guarding in the lumbar paraspinal muscles, negative straight leg raise bilaterally, and trace weakness during dorsiflexion/plantarflexion. The patient is currently prescribed Hydrochlorothiazide, Simvastatin, Tylenol, Disalcid, and Hydrocodone. Diagnostic imaging was not included, though progress note dated 04/01/15 indicates that this patient underwent MRI imaging of the lumbar spine in January 2006, stating: "This did show degenerative changes throughout the lumbar spine with some borderline spinal stenosis at L4-L5 and L5-S1, with some focal disc bulging noted at L4-L5 and L5-S1 as well as facet arthropathy." Patient is currently retired. For special diagnostics, ACOEM Guidelines page 303 states, "Unequivocal and equivocal objective findings that identify specific nerve compromise on neurological examination are sufficient evidence to warrant imaging in patients who do not respond well to treatment and who could consider surgery an option. Neurological examination is less clear; however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study." ODG Guidelines on low back chapter MRI topic states that "MRIs are test of choice for patients with prior back surgery, but for uncomplicated low back pain with radiculopathy, not recommended until at least 1 month of conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology" such as a tumor, infection, fracture, nerve compromise, recurrent disk herniation. In regard to the repeat lumbar MRI, the requesting provider has not included documentation of severe progressive neurological deficit to warrant repeat imaging. This patient underwent MRI imaging in January 2006; however, the report was not made available for review. Progress note dated 04/01/15 includes subjective complaints of radiating pain in the bilateral lower extremities, though the physical examination does not reveal any significant neurological deficit, such as decreased sensation along a specific dermatomal distribution. The examination findings do reveal some trace weakness to plantarflexion and dorsiflexion, but note a negative straight leg raise test bilaterally. ACOEM and ODG require documentation of progressive neurological deficit or examination "red-flags" indicative of nerve compromise to substantiate repeat imaging, no such findings are included. Therefore, the request is not medically necessary.

Trial of Flexeril 7.5mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain), Cyclobenzaprine (Flexeril).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66.

Decision rationale: The patient presents on 04/01/15 with neck pain, and unrated lower back pain which radiates into the bilateral lower extremities, and associated numbness and tingling in the bilateral lower extremities. The patient's date of injury is 04/29/05. Patient has no documented surgical history directed at these complaints. The request is for trial of Flexeril 7.5MG (DOS 04/01/2015). The RFA is dated 04/07/15. Physical examination dated 04/01/15 reveals flattened lumbar lordosis, spasms and guarding in the lumbar paraspinal muscles, negative straight leg raise bilaterally, and trace weakness during dorsiflexion/plantarflexion. The patient is currently prescribed Hydrochlorothiazide, Simvastatin, Tylenol, Disalcid, and Hydrocodone. Diagnostic imaging was not included, though progress note dated 04/01/15 indicates that this patient underwent MRI imaging of the lumbar spine in January 2006, stating: "This did show degenerative changes throughout the lumbar spine with some borderline spinal stenosis at L4-L5 and L5-S1, with some focal disc bulging noted at L4-L5 and L5-S1 as well as facet arthropathy." Patient is currently retired. MTUS Chronic Pain Medical Treatment Guidelines, page 63-66 states: "Muscle relaxants: Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. The most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions." In regard to the trial of Flexeril, the requesting provider has specified an excessive duration of therapy. Utilization review modified the original request for Flexeril 7.5MG #90 DOS 04/01/15 to allow for 20 tablets to be dispensed to the patient, noting MTUS guidelines recommending only short-term use. UR appeal statement dated 04/24/15 seeks the additional 70 tablets, noting that the patient reports some relief attributed to Flexeril. Regardless of documented efficacy, MTUS guidelines only support this medication for 2-3 week courses of therapy; the UR modified amount falls within these recommendations. The original request for 90 tablets does not imply the intent to use this medication short-term and cannot be substantiated. Therefore, the request is not medically necessary.