

Case Number:	CM14-0091365		
Date Assigned:	07/25/2014	Date of Injury:	05/06/2010
Decision Date:	09/19/2014	UR Denial Date:	06/10/2014
Priority:	Standard	Application Received:	06/18/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 40-year-old female who reported injury on 05/06/2012. Reportedly, the injured worker was at a patient's house, and when she opened a front wheel walker, her mid-back started to spasm in the thoracic region. The injured worker's treatment history included physical therapy, thoracic epidural steroid injections, aquatic therapy, bone growth stimulator, psychotherapy, biofeedback, facet joint injections, bilateral posterior fusion C6-8, and complete discectomy and partial corpectomy T9 and T10, anterior fusion T9-10. The injured worker was evaluated on 05/27/2014, and it was documented the injured worker complained of midback pain that radiates to the lateral and anterior chest. The most recent surgery was on 01/17/2014. She has had posterior fusion at C6-7 and C7-8, as well as bone graft at T4-5, T5-6, T8-9, and T9-10. She currently had hardware at T4 through T10. The pain was moderate, constant and followed no typical pattern. The pain was sharp, pressure, dull/aching, and stabbing. She had numbness. She describes weakness in her posterior. She was unable to go to work, do chores, yard work, shopping, socialize, recreational activities, and exercise. Physical therapy, heat and ice treatments, and psychotherapy provided moderate relief. Previous surgery provided moderate relief. Physical examination revealed pertinent positives included joint stiffness at thoracic and lumbar spine, restriction of motion of ribs, and muscle weakness in her back. Medications included fentanyl, Dilaudid, morphine, OxyContin, Norco, Soma, Zanaflex, Valium, Cymbalta, Neurontin, Klonopin, and Xanax. Diagnoses included thoracic discogenic pain, thoracic radiculitis myofascial pain syndrome, history of thoracic fusion T6 through T8, history of fusion T4 through T10, depression, anxiety, conversion disorder, insomnia, and history of suicidal ideation. The provider noted the injured worker complains of somnolence with Skelaxin, and has stopped. The provider noted the injured worker reported she was to continue with TENS

unit she has at home, and strengthening exercises. The Request for Authorization or rationale were not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY 2-3 TIMES/WEEK FOR 12 WEEKS; THORACIC SPINE:

Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The request is not medically necessary. The California MTUS Guidelines may support up to 10 visits of physical therapy for the treatment of unspecified myalgia and myositis to promote functional improvement. The documents submitted indicated the injured worker has had conservative care to include physical therapy. The provider failed to indicate long-term functional goals and outcome measurements of home exercise regimen. Additionally, the documents indicated the injured worker had moderate relief with prior therapy. The request submitted will exceed recommended amount of visits per the guideline. Given the above, the request for physical therapy 2-3 times/week for 12 weeks for the thoracic spine is not medically necessary.

SKELAXIN (METAXALONE) 800MG TID PRN #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NON SEDATING MUSCLE RELAXANTS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Muscle Relaxant & Skelaxin Page(s): 63,64.

Decision rationale: The requested service is not medically necessary. According to California (MTUS) Chronic Pain Medical Guideline, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. The guideline also states Skelaxin is recommended with caution as a second-line option for short-term pain relief in patients with Chronic LBP. Metaxalone (marketed by ██████████ under the brand name Skelaxin) is a muscle relaxant that is reported to be relatively non-sedating. The documentation submitted lacked evidence of outcome measurements of conservative care such as prior physical therapy sessions and medication pain management. The documents submitted failed to indicate duration of use of medication. There was a lack of documentation provided on her long-term goals of functional

improvement of her home exercise regimen. As, such, the request for Skelaxin (Metaxalone) 800 mg tid prn #90 is not medically necessary.

VALIUM (DIAZEPAM) 5MG QHS #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines BENZODIAZEPINES.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: Utilization Schedule (MTUS) Guidelines do not recommend Benzodiazepines for long-term use because long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. Furthermore, there was lack of documentation on the injured worker using the VAS scale to measure functional improvement after the injured worker takes the medication. As such, the request for Valium (Diazepam) qhs # 30 is not medically necessary.