

Case Number:	CM15-0122356		
Date Assigned:	07/06/2015	Date of Injury:	02/17/2009
Decision Date:	09/01/2015	UR Denial Date:	05/30/2015
Priority:	Standard	Application Received:	06/25/2015

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 York
 Certification(s)/Specialty: Anesthesiology

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 58 male, who sustained an industrial injury on February 17, 2009. He reported slipping and falling on a wet floor. The injured worker was diagnosed as having cervical radiculopathy, spinal/lumbar degenerative disc disease, low back pain, sprain lumbar region, sprain of neck, lumbar radiculopathy, and backache unspecified spinal. Diagnostic studies to date have included: On April 15, 2009, an MRI of the cervical spine revealed cervical 5-6 disc degeneration and broad-based protrusion with flattening of the cord with canal diameter of 6 millimeter. There was multilevel uncovertebral spurring and facet arthropathy with neuroforaminal stenosis. There was severe cervical 5-6 and cervical 6-7 foraminal stenosis. There was disc degeneration and disc-osteophyte complexes at cervical 3-4 and cervical 4-5, and a small annular bulge at C-7. On March 26, 2013, an MRI of the lumbar spine revealed at the lumbar 2-3 level mild to moderate disc degeneration with 2-3 millimeter circumferential bulge and osteophyte, greater on the left side where the lateral recess and neural foramen are moderately narrowed. There was mild disc degeneration, bulging, and bilateral foraminal narrowing at lumbar 1-2, lumbar 3-4, and lumbar 4-5. On May 14, 2014, an electromyography/NCS nerve conduction study of the bilateral upper extremities revealed bilateral carpal tunnel syndrome, bilateral cervical 7 chronic radiculopathy, and slight conduction velocity slowing at the right cubital tunnel but may be due to the cervical radiculopathy. Treatment to date has included lumbar epidural steroid injections, medial branch blocks, temporary total disability, work modifications, and medications including opioid analgesic, antidepressant, muscle relaxant, and anti-epilepsy. There were no noted previous injuries or dates

of injury, and no noted comorbidities. His work status is temporarily totally disabled as modified duty is not available. Work restrictions include no repetitive bending, no continuous bending, no working more than 4 hours per day, no prolonged neck flexion, no lifting greater than 20 pounds, sit and stand as needed (change position as needed). On May 19, 2015, the injured worker complains of neck and left hip pain. The physical exam revealed a slow and antalgic gait, restricted cervical range of motion, tenderness and tight muscle band on both sides of the cervical paravertebral muscles, and tenderness at the paracervical muscles and trapezius. There was a lumbar spine surgical scar, restricted lumbar range of motion, and hypertonicity, tenderness and tight muscle band on both sides of the paravertebral muscles, and bilateral positive facet loading. The motor exam of the bilateral upper and lower extremities was normal, except for decreased strength of the left upper extremity muscles and right hand abductor pollicis brevis muscle. There was decreased sensation over the left medial hand, lateral hand, medial forearm, and lateral forearm. There were decreased deep tendon reflexes of the bilateral lower extremities. The treatment plan includes continuing Skelaxin 800mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Skelaxin 800mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 61, 107.

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

Decision rationale: According to the CA MTUS guidelines, Metaxalone (Skelaxin) is recommended as a second-line option for short-term (less than two weeks) treatment of acute LBP and for short-term treatment of acute exacerbations in patients with chronic LBP. Metaxalone is reported to be a relatively non-sedating muscle relaxant. The exact mechanism of action is unknown, but the effect is presumed to be due to general depression of the central nervous system. A hypersensitivity reaction (rash) has been reported. It is to be used with caution in patients with renal and/or hepatic failure. The medical records show that the injured worker has been taking Skelaxin since at least December, 2014, which exceeds the guideline recommendations. Therefore, the Skelaxin is not medically necessary.