

<b>Case Number:</b>	CM15-0029910		
<b>Date Assigned:</b>	02/23/2015	<b>Date of Injury:</b>	03/04/2002
<b>Decision Date:</b>	04/08/2015	<b>UR Denial Date:</b>	02/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/18/2015

### 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, Michigan, 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 36-year-old male, who sustained an industrial injury on 03/04/2002. The diagnoses have included chronic low back pain, history of L4-5 fusion, disc annular tears at multiple levels, bilateral lower extremity neuropathic radiculopathy, and hyperreflexia. Noted treatments to date have included surgeries, injection, massage, and medications. Diagnostics to date have included MRI which showed at L4-5 a 3.3mm disc protrusion that effaces the thecal sac with bilateral neural foraminal narrowing and a 2.5, 2.1, and 2.0mm disc protrusion or herniation at L4-5 per progress note. In the same progress note dated 01/30/2015, the injured worker presented with complaints of back stiffness, numbness in left leg, and radicular pain in the left leg. The treating physician reported the injured worker has attempted to wean the medications with increased pain, suffering, and decreased functional capacity. Utilization Review determination on 02/12/2015 non-certified the request for Lumbar CT Scan to ascertain stability of fusion, Flexeril 10mg #90 and modified the request for Ativan 0.5mg #30, Gabapentin 600mg #360, and Zanaflex 4mg #60 to Ativan 0.5mg one at bedtime (QHS) on alternate days #15 tablets for a 30 days usage in order to initiate a weaning plan, Gabapentin 600mg six tablets a day #180 tablets for a 30 day period with no refills, and Zanaflex 4mg once a day #30 for a 30 day usage with no refills citing Medical Treatment Utilization Schedule and Official Disability Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar CT Scan to ascertain stability of fusion: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back Chapter, CT.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**Decision rationale:** According to MTUS guideline, CT scan of the lumbar spine is able to identify low back pathology in case of disc protrusion, spinal stenosis, post laminectomy syndrome and Cauda Equina syndrome. CT or MRI of the back is indicated when cauda equina tumor, infection, or fracture are strongly suspected and plain film radiographs are negative. There is no documentation supporting that the patient developed a serious condition or have a dramatic change of his condition requiring a new imaging study. It has been documented in previous imaging studies that the patient has partial fusion and pseudoarthrosis. The necessity of a lumbar CT scan should be assessed by a spine surgeon. Therefore, the request for a CT scan of lumbar spine is not medically necessary.

**Flexeril 10mg, #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

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

**Decision rationale:** According to MTUS guidelines, Flexeril, a non sedating muscle relaxants, is recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic spasm and pain. Efficacy appears to diminish over time and prolonged use may cause dependence. There is no recent documentation of pain and spasticity improvement. Therefore the request for authorization FLEXERIL 10 MG, # 90 is not medically necessary.

**Ativan 0.5mg, #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

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

**Decision rationale:** According to MTUS guidelines, benzodiazepines are not recommended for long term use for pain management because of unproven long term efficacy and because of the risk of dependence. Most guidelines limit their use to 4 weeks. There is no documentation of

rational and efficacy of previous use of Ativan. Therefore the use of 30 Ativan 0.5mg is not medically necessary.

**Gabapentin 600mg, #360: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): (s) 16, 18.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 49.

**Decision rationale:** According to MTUS guidelines, "Gabapentin is an anti-epilepsy drug (AEDs - also referred to as anti-convulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain". There was no documentation that the patient is suffering from neuropathic pain including diabetic neuropathic pain or post-herpetic neuralgia condition. There is no documentation of efficacy and safety from previous use of Gabapentin. Therefore, the prescription of Gabapentin 600mg #360 is not medically necessary.

**Zanaflex 4mg, #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

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

**Decision rationale:** According to MTUS guidelines, a non-sedating muscle relaxants is recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic lumbosacral pain. Efficacy appears to diminish over time and prolonged use may cause dependence. The patient in this case developed continuous pain, does not have clear exacerbation of back pain and spasm and the prolonged use of Zanaflex is not justified. Furthermore, there is no clear evidence of chronic myofascial pain and spasm. Therefore, the request for Zanaflex 4mg #60 is not medically necessary.