

<b>Case Number:</b>	CM14-0144872		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	06/25/2009
<b>Decision Date:</b>	10/17/2014	<b>UR Denial Date:</b>	08/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/08/2014

### 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 a 64-year-old female, who reported an injury on 06/25/2009. The mechanism of injury was not submitted for clinical review. The diagnoses included chronic low back pain, lumbar degenerative disc disease, grade 1 degeneration spondylolisthesis at L4-5, central disc protrusion, status post posterior lumbar decompression and fixation. The previous treatments included medication, surgery, chiropractic care, acupuncture. Within the clinical note dated 06/17/2014, it was reported the injured worker was 2 weeks status post lumbar decompression laminectomy with posterolateral fusion and fixation. The injured worker reported the ability to walk 10 to 15 minutes around her home. The injured worker reported her pain has been controlled with Percocet; he rated her pain 5/10 in severity. Upon physical examination, the provider noted the injured worker had a normal healing incision with no erythema or drainage. The injured worker had full muscle strength in the bilateral lower extremities at 5/5. The provider indicated the injured worker had decreased sensation to pinprick on the right lateral greater than medial lower leg, otherwise intact pinprick sensation in all lower extremity dermatomes. The request submitted is for Zanaflex and an external bone growth stimulator for purchase. However, a rationale was not submitted for clinical review. The Request for Authorization was not submitted for clinical review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Zanaflex 4mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

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

**Decision rationale:** The California MTUS Guidelines recommends non-sedating muscle relaxants with caution as a second line option for short-term treatment of acute exacerbation in patients with chronic low back pain. The guidelines note the medication is not recommended to be used for longer than 2 to 3 weeks. The clinical documentation lacks significant subjective and objective findings warranting the medical necessity for the request. The request submitted failed to provide the frequency of the medication. Additionally, the injured worker had been utilizing the medication since at least 06/2014, which exceeds the guidelines' recommendation of short-term use of 2 to 3 weeks. Therefore, the request is not medically necessary.

**External bone growth stimulator. Purchase.:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, electrical bone growth stimulators.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Bone growth stimulators (BGS).

**Decision rationale:** The Official Disability Guidelines notes bone growth stimulators are under study. There is conflicting evidence, so case by case recommendations are necessary. Some limited evidence exists for improving the fusion rate of spinal fusion surgery in high risk cases. There is no consistent medical evidence to support or refute the use of these devices for improving patient outcomes, and there may be a beneficial effect on fusion rate in patients at high risk. Criteria for use of the bone growth stimulator include that either invasive or noninvasive methods of electrical bone growth stimulation may be considered medically necessary as an adjunct to spinal fusion surgery for patients with any of the following risk factors for failed fusion, including 1 or more previous failed spinal fusions, grade 3 or worse spondylolisthesis, fusion to be performed at more than 1 level, current smoking habit, diabetes, renal disease, alcoholism, significant osteoporosis that has been demonstrated on radiographs. The clinical documentation submitted does not indicate the injured worker had a failed fusion surgery. Clinical documentation submitted does not indicate the injured worker has grade 3 or worse spondylolisthesis; it indicates the injured worker has grade 1. There is no indication the injured worker is a current smoker. Additionally, there is no significant documentation of osteoporosis. Therefore, the request for external bone growth stimulator, purchase. is not medically necessary and appropriate.

