

<b>Case Number:</b>	CM14-0014654		
<b>Date Assigned:</b>	02/28/2014	<b>Date of Injury:</b>	02/12/2003
<b>Decision Date:</b>	06/30/2014	<b>UR Denial Date:</b>	01/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/05/2014

### 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 and Rehabilitation and is licensed to practice in Texas. 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 57-year-old male who reported an injury 02/12/2003. The mechanism of injury was not provided. The diagnoses included chronic low back pain, status post L4-S1 interbody fusion on 02/17/2006. Per the 01/15/2014 clinical note, the injured worker reported radiating low back pain, particularly into the lower left extremity. The injured worker reported pain and functional improvement with his medications. The injured worker rated his pain at 5/10 with medication and 10/10 without medication. An examination of the lumbar spine noted midline tenderness from T11-L4 with mild spasms. The injured worker had decreased lumbar spine range of motion and a positive straight leg raise on the left at 50 degrees. The injured worker's medication regimen included Kadian 20 mg, Percocet 10/325 mg, Lyrica 150 mg, omeprazole 20 mg, and Lidoderm 5% patches. In the treatment plan, the provider indicated to discontinue Tizanidine as the injured worker had not required it over the last thirty (30) days. The Request for Authorization Form for Zanaflex was submitted on 01/10/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ZANAFLEX 4MG, AS NEEDED:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Zanaflex (Tizanidine).

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

**Decision rationale:** The Chronic Pain Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbations in patients with chronic low back pain. Efficacy appears to diminish over time and prolonged use of some medications in this class may lead to dependence. The medical records provided indicate a prescription for Zanaflex since at least 06/28/2013. The guidelines do not support the long term use of muscle relaxants. The efficacy of the medication cannot be determined as the injured worker was no longer taking the medication. The rationale for the submitted request was not provided. In addition, the submitted request does not specify a quantity. The medical necessity for continued use of Zanaflex was not established. As such, the request is not medically necessary.