| Case Number: | CM14-0124891 | | |
|---|---|---|---|
| Date Assigned: | 08/11/2014 | Date of Injury: | 01/04/2012 |
| Decision Date: | 09/25/2014 | UR Denial Date: | 07/15/2014 |
| Priority: | Standard | Application Received: | 08/07/2014 |

## 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in California. 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:

According to the records made available for review, this is a 53-year-old male with a 1/4/12 date of injury. At the time (6/27/14) of the request for authorization for Naprosyn 550mg #60 x 3 refills, Zanaflex 4mg #60, and Zanaflex 40mg #60 x 3 refills, there is documentation of subjective (persistent low back pain) and objective (no significant change) findings, current diagnoses (low back pain/coccydynia and low-grade right knee pain), and treatment to date (medication including Zanaflex for at least 4 months). Regarding Zanaflex 4mg #60 and Zanaflex 40mg #60 x 3 refills, there is no documentation of spasticity; functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications with use of Zanaflex; and intended short-term treatment.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Naprosyn 550mg #60 x 3 refills.:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67,68,72.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe osteoarthritis pain, acute low back pain, chronic low back pain, or exacerbations of chronic pain, as criteria necessary to support the medical necessity of NSAIDs. Within the medical information available for review, there is documentation of diagnoses of low back pain/coccydynia and low-grade right knee pain. In addition, there is documentation of chronic low back pain. Therefore, based on guidelines and a review of the evidence, the request for Naprosyn 550mg #60 x 3 refills is medically necessary.

**Zanaflex 4mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs (Tizanidine (Zanaflex)) Page(s): 66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain).

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of spasticity, as criteria necessary to support the medical necessity of Zanaflex. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended as a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Within the medical information available for review, there is documentation of diagnoses of low back pain/coccydynia and low-grade right knee pain. In addition, there is documentation of treatment with Zanaflex for at least 4 months. However, there is no documentation of spasticity. In addition, given documentation of treatment with Zanaflex for at least 4 months, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications with use of Zanaflex. In addition, there is no documentation of intended short-term treatment. Therefore, based on guidelines and a review of the evidence, the request for Zanaflex 4mg #60 is not medically necessary.

**Zanaflex 4mg #60 x 3 refills.:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs (Tizanidine (Zanaflex)) Page(s): 66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain).

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of spasticity, as criteria necessary to support the medical necessity of Zanaflex. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended as a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Within the medical information available for review, there is documentation of diagnoses of status post right shoulder scope with residual adhesive capsulitis, right shoulder impingement/periscapular strain, cervical spine strain/sprain, radiculopathy right upper extremity, and bilateral forearm/wrist strain/sprain with carpal tunnel syndrome. In addition, there is documentation of ongoing use of Zanaflex and spasm. However, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services with use of Zanaflex. In addition, there is no documentation of intended short-term treatment. Therefore, based on guidelines and a review of the evidence, the request for Zanaflex 40mg #60 x 3 refills is not medically necessary.