

<b>Case Number:</b>	CM14-0196155		
<b>Date Assigned:</b>	12/01/2014	<b>Date of Injury:</b>	03/17/2008
<b>Decision Date:</b>	12/14/2015	<b>UR Denial Date:</b>	11/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/24/2014

### 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. 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: Massachusetts

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 59 year old female who sustained an industrial injury on 3-17-08. The injured worker reported pain in the back with lower extremity radiation. A review of the medical records indicates that the injured worker is undergoing treatments for cervical spondylosis without myelopathy, spondylosis lumbosacral, sciatica, pain in joint-lower leg, and lumbago. Provider documentation dated 7-17-14 noted the work status as permanent and stationary. Treatment has included electromyography, nerve conduction velocity study (10-12-09), lumbar spine magnetic resonance imaging (2008), cervical spine magnetic resonance imaging (2008), Morphine Sulfate since at least April of 2014, Gabapentin since at least April of 2014, Zanaflex since at least April of 2014, and transcutaneous electrical nerve stimulation unit. Objective findings dated 7-17-14 were notable for lumbar spine with bilateral spasms and guarding to paraspinous musculature, paravertebral muscle with tenderness and palpable tight muscle bands, right trapezius with tenderness and palpable tight muscle bands. The original utilization review (11-7-14) denied a request for Zanaflex 4mg #30.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Zanaflex 4mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**Decision rationale:** According to the MTUS, Tizanidine (Zanaflex, generic available) is a centrally acting alpha<sub>2</sub>-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. (Malanga, 2008) Eight studies have demonstrated efficacy for low back pain. (Chou, 2007) One study (conducted only in females) demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain. (Malanga, 2002) May also provide benefit as an adjunct treatment for fibromyalgia. (ICSI, 2007) Side effects: somnolence, dizziness, dry mouth, hypotension, weakness, hepatotoxicity (LFTs should be monitored baseline, 1, 3, and 6 months). (See, 2008) Dosing: 4 mg initial dose; titrate gradually by 2 - 4 mg every 6 - 8 hours until therapeutic effect with tolerable side-effects; maximum 36 mg per day. (See, 2008) Use with caution in renal impairment; should be avoided in hepatic impairment. Tizanidine use has been associated with hepatic aminotransaminase elevations that are usually asymptomatic and reversible with discontinuation. The MTUS recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in injured workers with chronic LBP. (Chou, 2007) (Mens, 2005) (VanTulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in injured workers driving motor vehicles or operating heavy machinery. Drugs with the most limited published evidence in terms of clinical effectiveness include chlorzoxazone, methocarbamol, dantrolene and baclofen. (Chou, 2004) According to a recent review in American Family Physician, skeletal muscle relaxants are the most widely prescribed drug class for musculoskeletal conditions (18.5% of prescriptions), and the most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. (See2, 2008) According to the documents available for review, the injured worker has been utilizing zanaflex for long-term treatment of chronic pain condition. This is in contrast to the MTUS recommendations for short-term treatment of acute exacerbations. Therefore, at this time, the request is not medically necessary.