

<b>Case Number:</b>	CM15-0182118		
<b>Date Assigned:</b>	09/23/2015	<b>Date of Injury:</b>	05/13/2004
<b>Decision Date:</b>	11/10/2015	<b>UR Denial Date:</b>	09/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/15/2015

### 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: California, North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 sustained an industrial injury on 05-13-2004. She has reported subsequent low back pain and was diagnosed with lumbosacral spondylosis, lumbar facet arthropathy and thoracic and lumbar neuritis and radiculitis. MRI of the lumbar spine on 10-02-2011 and lumbar x-rays on 09-12-2011 were noted to show facet arthropathy of L3-S1. Treatment to date has included pain medication, therapy, left sacroiliac injection, application of heat and ice, transcutaneous electrical nerve stimulator (TENS) unit, radiofrequency ablation of L3-L5 and surgery. Radiofrequency ablation was noted to have provided 70% pain relief and left sacroiliac injection was noted to provide 80% pain relief. Medication was documented to decrease pain but there was no documentation as to the duration of pain relief or any objective functional improvement with use. Documentation shows that Tizanidine was prescribed since at least 02-17-2015 for use as needed for insomnia and spasm. There is no discussion of the injured worker's sleep hygiene or the effect of Tizanidine on sleep quality. In a progress note dated 09-01-2015, the injured worker reported 7 out of 10 low back pain and sciatic pain radiating to the left posterior thigh to the calf with weakness in the leg. Objective examination findings showed tenderness to palpation of the bilateral lumbar facet joints from L3-L5, pain with facet loading maneuvers and positive bilateral lumbar radicular signs. A request for authorization of Tizanidine 4 mg qty 100 was submitted. As per the 09-10-2015 utilization review, the request for Tizanidine 4 mg qty 100 was non-certified.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Tizanidine 4 mg Qty 100:** 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:** Ca MTUS Guidelines state that muscle relaxants such as Tizanidine (Zanaflex) are recommended for use with caution for the short-term treatment of acute exacerbations of muscle spasms in patients with chronic low back pain. This medication is not recommended for long-term use. In this case, there is no documentation of significant pain relief or functional improvement as a result of the use of Tizanidine. Thus, there is no clear evidence of efficacy for the use of this medication. The patient is being prescribed Tizanidine for long-term use, which is not recommended. Therefore, the request is not medically necessary or appropriate.