

Case Number:	CM15-0026320		
Date Assigned:	02/18/2015	Date of Injury:	08/31/2008
Decision Date:	03/31/2015	UR Denial Date:	02/05/2015
Priority:	Standard	Application Received:	02/11/2015

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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular Medicine

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 46 year old male, who sustained an industrial injury on 08/31/2008. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. Diagnoses include knee pain, myofascial pain syndrome, facet syndrome, back pain, and cervalgia. Treatment to date has included home exercise program, medication regimen, and use of a transcutaneous electrical nerve stimulation unit. In a progress note dated 01/28/2015 the treating provider reports low back pain, arm pain, bilateral groin/anterior thigh pain, dorsal thoracic pain radiating to the bilateral arms, bilateral lower extremity pain, and aching and burning bilateral knee pain. The pain is rated as a seven out of ten. The treating physician requested the medications of Flexeril and Tizanidine noting prior use of Flexeril for muscle tightness and Tizanidine for muscle spasms at night. On 02/04/2015 Utilization Review non-certified the requested treatments of the prescriptions for Flexeril 10mg with a quantity of 60 with 2 refills and Tizanidine 4mg with a quantity of 60 with 2 refills between the dates of 01/28/2015 and 05/04/2015, noting the California Chronic Pain Medical Treatment Guidelines (May 2009).

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexeril 10mg, #60 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): pages 41-42 and page 64.

Decision rationale: Flexeril 10mg #60 with 2 refills is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that Cyclobenzaprine is not recommended to be used for longer than 2-3 weeks. The documentation indicates that the patient has already been on Cyclobenzaprine. There is no evidence of functional improvement from prior use. There are no extenuating circumstances documented that would necessitate continuing this medication beyond the 2-3 week time frame. The request for continued Flexeril is not medically necessary.

Tizanidine 4mg, #60 with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine (Zanaflex, generic available) Muscle relaxants (for pain) Page(s): 66 and 63.

Decision rationale: Tizanidine 4mg # 60 with 2 refills is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that muscle relaxants are 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. Tizanidine is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. The documentation indicates that the patient has chronic low back pain. There is no evidence of functional improvement on prior Tizanidine therefore the request for Tizanidine is not medically necessary.