

<b>Case Number:</b>	CM15-0033541		
<b>Date Assigned:</b>	03/26/2015	<b>Date of Injury:</b>	04/14/2004
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	01/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/23/2015

### 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: Arizona, California

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 45 year old female, who sustained an industrial injury on 04/14/2004. She has reported injury to the low back. The diagnoses have included chronic low back pain and lumbar spine degenerative disc disease. Treatment to date has included medications, diagnostic studies, injections, and home exercise program. Medications have included Norco, Zanaflex, and Fentanyl patch. A progress report from the treating provider, dated 01/06/2015, documented an evaluation with the injured worker. Currently, the injured worker complains of continued intractable low back pain; pain is rated 10/10 on the visual analog scale with medications, and 4-5/10 with medications; and Norflex did not help. Objective findings included tenderness to palpation over the lumbar paraspinal musculature; lumbar spine spasm; painful and limited range of motion; positive straight-leg-raising on the right; and decreased sensation bilaterally at L4-5 and L5-S1. The treatment plan included prescription medications. The current request is for Zanaflex 4 mg #90.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Zanaflex 4mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-64.

**Decision rationale:** According to the MTUS guidelines, Zanaflex is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. Eight studies have demonstrated efficacy for low back pain. It falls under the category of muscle relaxants. According to the MTUS guidelines, muscle relaxants are to be used with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most low back pain 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. In this case, the claimant had been on muscle relaxants the prior months (Tizanidine and SOMA). Continued and chronic use of muscle relaxants /antispasmodics is not medically necessary. Therefore, Zanaflex is not medically necessary.