

<b>Case Number:</b>	CM15-0236389		
<b>Date Assigned:</b>	12/11/2015	<b>Date of Injury:</b>	08/14/2015
<b>Decision Date:</b>	01/15/2016	<b>UR Denial Date:</b>	11/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/03/2015

### 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

Certification(s)/Specialty: Preventive Medicine, Occupational 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 49 year old male, who sustained an industrial injury on 8-14-15. He reported right hand pain. The injured worker was diagnosed as having complex regional pain syndrome of the right upper limb and disorder of the autonomic nervous system. Treatment to date has included 7 physical therapy sessions and medication including Aspirin, Gabapentin, Lipitor, Lopressor, and Plavix. Physical exam findings on 11-12-15 included right hand 4th and 5th finger atrophy. Dysesthesia to light touch and pressure were noted in the right hand. The injured worker was unable to make a fist with the right hand. Edema was also present. On 11-12-15, the injured worker complained of right hand and arm pain. On 11-12-15, the treating physician requested authorization for Zanaflex 4mg #30. On 11-24-15 the request was non-certified by utilization review.

### 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, Section(s): Muscle relaxants (for pain).

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

**Decision rationale:** Zanaflex is FDA approved for the management of spasticity. The use of muscle relaxants for pain is recommended with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic low back pain. There is some support for using Zanaflex in the treatment of myofascial pain syndrome and as an adjunct treatment for fibromyalgia. There is no indication that the injured worker is suffering from spasticity. This medication has been prescribed to be taken once a day, at bedtime, every night. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. The request for Zanaflex 4mg #30 is determined to not be medically necessary.