

Case Number:	CM15-0078334		
Date Assigned:	04/29/2015	Date of Injury:	07/24/2007
Decision Date:	05/28/2015	UR Denial Date:	04/01/2015
Priority:	Standard	Application Received:	04/23/2015

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: California
 Certification(s)/Specialty: Emergency 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 40-year-old male patient who sustained an industrial injury on 07/24/2007. A pain management visit dated 08/14/2014 reported subjective complaints of neck pain, low back pain that radiates into the bilateral lower extremities. He states that he is status post administration of caudal epidural injection that offered moderate overall improvement. He reports moderate functional improvement with use of the transcutaneous nerve stimulator unit. He states the Ibuprofen is not as effective. Diagnostic testing to include: magnetic resonance imaging, computerized tomography study. The following diagnoses are applied: failed back surgery syndrome, lumbar; lumbar post laminectomy syndrome; lumbar radiculopathy; status post fusion, lumbar; chronic constipation; erectile dysfunction; gastroesophageal reflux, medication related dyspepsia, and chronic pain. Another pain management follow up visit dated 05/22/2014 reported no change in subjective complaints. No medication changes, of any change to the treating diagnoses. An injection was administered this visit. The plan of care involved; recommending Tizanidine, Viagra, and return for follow up in one month.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tizanidine 2mg 2x daily #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/antispasmodics Page(s): 60.

Decision rationale: Zanaflex (Tizanidine) is an antispasmodic muscle relaxant. It is FDA approved for muscle spasms. As per MTUS guidelines, muscle relaxants should be used for short term use and for flare ups only. There is documentation of benefit. Patient has been on this medication chronically. Chronic use of a muscle relaxant is not medically necessary. Tizanidine is not medically necessary.