

Case Number:	CM13-0061149		
Date Assigned:	12/30/2013	Date of Injury:	08/07/2006
Decision Date:	05/08/2014	UR Denial Date:	11/15/2013
Priority:	Standard	Application Received:	12/04/2013

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 73-year-old female who reported an injury on 08/07/2006. The mechanism of injury was not provided in the medical records. Her symptoms included neck pain that radiated to the left with pain to the left shoulder. The injured worker's pain is rated at an 8/10 with medications and a 9/10 without medications. Physical examination revealed tenderness to the left anterior shoulder, left posterior shoulder, and left shoulder. The range of motion of the left shoulder was decreased due to pain. Examination of the cervical spine revealed pain increased with flexion, extension, and rotation. Motor exam showed a decreased strength. The injured worker was diagnosed with complete rupture of the rotator cuff. Past medical treatment included acupuncture and medications. The request for authorization was not provided in the medical records. Therefore, the clinical note from the day the treatment was requested is unclear.

IMR ISSUES, DECISIONS AND RATIONALES

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

TIZANIDINE HCL 2 MG #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine Zanaflex Page(s): 66.

Decision rationale: According to California MTUS Guidelines, tizanidine is a centrally acting alpha 2-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. One study demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome, and the authors recommended its use as a first line option to treat myofascial pain. It may also provide benefit as an adjunct treatment for fibromyalgia. The most recent clinical note submitted indicated the patient was currently taking the prescribed medications that include tizanidine, to reduce pain. However, the documentation failed to provide evidence of improvement in function, a decrease in musculoskeletal pain, or a decrease in muscle spasm. Additionally, the request as submitted failed to indicate the frequency in which this medication is to be taken. Therefore, the request for tizanidine HCL 2 mg #30 is non-certified.