

<b>Case Number:</b>	CM13-0067084		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	06/08/2000
<b>Decision Date:</b>	04/22/2014	<b>UR Denial Date:</b>	11/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/17/2013

### 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 has a subspecialty in Pediatric Rehabilitation Medicine and is licensed to practice in Texas. 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 patient reported an injury on 06/08/2000. The documentation indicates the patient has a Baclofen pump utilized to treat the patient's chronic pain which includes bilateral arms and legs. On the examination performed on 11/05/2013, the patient was noted to have dysesthesias and allodynia in all 4 extremities with no cyanosis and the patient was able to ambulate independently. The patient has been diagnosed with complex regional pain syndrome of the upper and lower extremities, status post intrathecal pump implant, opioid induced constipation, and medication induced sedation. The patient was seen most recently on 11/19/2013 for a routine pump refill.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**THE REQUEST FOR TIZANIDINE 4MG 1-2 AT BEDTIME #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic drugs Page(s): 66.

**Decision rationale:** According to California MTUS Guidelines, Tizanidine is a centrally alpha-2- adrenergic agonist that is FDA approved for the management of spasticity; however, it is unlabeled use for low back pain. In the case of this patient, the documentation indicates she has been utilizing a Baclofen pump for several months. However, it is unclear as to the medical necessity for utilization of Tizanidine when Baclofen is also a muscle relaxant. There is no documentation indicating the patient necessitates an additional muscle relaxant if the Baclofen has been effective in reducing her spasms and overall pain and discomfort. Therefore, without have a thorough rationale for the requested medication, the Tizanidine cannot be supported at this time. As such, the requested service is non-certified.