

Case Number:	CM14-0114813		
Date Assigned:	08/04/2014	Date of Injury:	06/09/2008
Decision Date:	09/10/2014	UR Denial Date:	07/16/2014
Priority:	Standard	Application Received:	07/22/2014

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 Orthopedic Surgery, and is licensed to practice in California. 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 56 year-old male who was reportedly injured on 06/09/2008. The mechanism of injury is noted as a fall. The most recent progress note dated 03/17/2014, indicates that there are ongoing complaints of neck pain, right shoulder pain and right upper extremity pain and numbness. Physical examination demonstrated decreased sensation on medial aspect of right hand; able to make a fist with right hand. No recent imaging studies available for review; however, there is note of old magnetic resonance images of the cervical spine dated 12/08/2009 and right shoulder dated 07/17/2012. Diagnosis; right carpal tunnel syndrome status post carpal tunnel release in 2010, neck pain, right shoulder pain, right wrist pain, and lumbar discectomy and spur removal in 2001. Previous treatment includes physical therapy, acupuncture, massage therapy and medications to include Norco, Ibuprofen, Lidoderm, Effexor, Triamterene, Pennsaid 1.5% and Gabapentin. A request was made for retrospective Tizanidine 4 mg #60 (DOS: 06/19/2014) which was not certified in the utilization review on 07/16/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective (DOS: 06/19/2014) Tizanidine 4mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs Page(s): 66.

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

Decision rationale: Zanaflex (Tizanidine) is a centrally acting alpha 2-adrenergic agonist that is food and drug administration approved for management of spasticity. It has an unlabeled use in low back pain. Muscle relaxants as a class are only indicated as second-line options for short-term treatment. It appears that this medication is being used on a chronic basis which is not supported by MTUS guidelines. Therefore, this medication is not considered medically necessary.