

<b>Case Number:</b>	CM15-0005367		
<b>Date Assigned:</b>	01/16/2015	<b>Date of Injury:</b>	05/21/2003
<b>Decision Date:</b>	03/30/2015	<b>UR Denial Date:</b>	12/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/12/2015

### 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: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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 58 year old female, who sustained a work related injury on 5/21/03. The diagnoses have included left shoulder derangement, left shoulder repair x 2, shoulder joint pain, shoulder-hand syndrome and depression. Treatments to date have included home exercise program, oral medications including Hydrocodone-acetaminophen and Tizanidine, rest, physical therapy, shoulder injections and left shoulder surgery x 2. In the PR-2 dated 11/12/14, the injured worker complains of severe left shoulder pain with left arm pain. On 12/18/14, Utilization Review modified prescription requests for Hydrocodone 10mg.-acetaminophen 325mg., #120 to Hydrocodone 10mg.-acetaminophen 325mg., #30 and Tizanidine 4mg., #30 with 5 refills to Tizanidine 4mg., #30 with 0 refills. The California MTUS, Chronic Pain Treatment Guidelines, were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tizanidine 4 mg #30 with 5 refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63.

**Decision rationale:** According to MTUS guidelines, a non sedating muscle relaxant is recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic lumbosacral pain. Efficacy appears to diminish over time and prolonged use may cause dependence. The patient was previously treated with Tizanidine for at least more than 4 months, which is considered a prolonged use of the drug. There is no continuous and objective documentation of the effect of the drug on patient pain, spasm and function. There is no recent documentation for recent pain exacerbation or failure of first line treatment medication. Therefore, the request for Tizanidine 4mg tablet #30, 5 refills is not medically necessary.