

<b>Case Number:</b>	CM15-0047275		
<b>Date Assigned:</b>	03/19/2015	<b>Date of Injury:</b>	02/01/2000
<b>Decision Date:</b>	04/24/2015	<b>UR Denial Date:</b>	02/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/12/2015

### 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 54-year-old female, who sustained an industrial injury on February 1, 2000. The injured worker reported back pain. The injured worker was diagnosed as having lumbar degenerative disc disease (DDD), positive discogram L5-S1, myofascial low back pain, bilateral sacroiliitis and bilateral facet pain. Treatment and diagnostic studies to date have included magnetic resonance imaging (MRI), discogram, acupuncture, physical therapy, chiropractic, epidural steroid injection and home exercise. A progress note dated February 5, 2015 the injured worker complains of back pain radiating to her right leg and at times the left leg. She rates her pain as 5/10. Physical exam provides there is lumbar tenderness with spasm and painful range of motion (ROM). It is noted there is anxiety and depression. The plan includes medication, X-ray and Transcutaneous Electrical Nerve Stimulation (TENS) unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) prescription of Tizanidine 2mg #60: 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. Tizanidine was used in this patient without clear evidence of spasm or objective monitoring of the drug effect on the patient condition. The patient in this case does not have clear evidence of spasm and the prolonged use of Tizanidine is not justified. The request of Tizanidine 2mg #60 is not medically necessary.