

Case Number:	CM15-0049815		
Date Assigned:	03/23/2015	Date of Injury:	06/27/2014
Decision Date:	05/06/2015	UR Denial Date:	03/07/2015
Priority:	Standard	Application Received:	03/16/2015

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: Texas, New York, California
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 53 year old female, who sustained an industrial injury on 06/27/2014. She has reported injury to the neck and left shoulder/arm. The diagnoses have included sprain of neck; sprain of shoulder/arm; cervicobrachial syndrome; left rotator cuff bursitis syndrome; and bicipital tenosynovitis. Treatment to date has included medications, diagnostic studies, acupuncture, TENS (transcutaneous electrical nerve stimulation) unit, and physical therapy. A progress report from the treating physician, dated 10/02/2014, documented an evaluation with the injured worker. Currently, the injured worker complains of severe pain across the neck and left shoulder down to the forearm, wrists, and fingers; the pain is associated with numbness and tingling in the forearms, wrists, and fingers on the left; and pain has been reduced with medications, heat, ice acupuncture, physical therapy, and TENS unit. Objective findings included tenderness to palpation of the biceps tendon and acromioclavicular joint on the left; limited range of motion in the bilateral shoulders; and shoulder impingement test is positive on the left. The treatment plan has included continuation of prescription medication, Tizanidine HCL.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tizanidine HCL 4 MG #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:Tizanidine (Zanaflex, generic available); Functional Restoration Approach to Chronic Pain Management Page(s): 66; 7.

Decision rationale: While page 66 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that tizanidine or Zanaflex is FDA approved in the management of spasticity but can be employed off-label for low back pain and is a first-line option for myofascial pain syndrome, this recommendation, however, is qualified by commentary made on page 7 of the MTUS Chronic Pain Medical Treatment Guidelines to the effect that an attending provider should incorporate some discussion of medication efficacy into his choice of recommendations. Here, no recent clinical progress notes were attached to the application for Independent Medical Review. The applicant's work status, functional status, and response to previous usage of tizanidine on or around the date of the Utilization Review Report, were not discussed, detailed, or expounded upon. The sole progress note on file contained no references to usage of tizanidine. Therefore, the request was not medically necessary.