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| <b>Case Number:</b>   | CM13-0062296 |                              |            |
| <b>Date Assigned:</b> | 01/29/2014   | <b>Date of Injury:</b>       | 08/24/2010 |
| <b>Decision Date:</b> | 03/26/2015   | <b>UR Denial Date:</b>       | 11/12/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 12/06/2013 |

### 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. 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 York  
 Certification(s)/Specialty: Internal 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 patient is a 35 year old female who was injured on 08/24/2009-08/24/2010. She reported her right shoulder aches and attributes this to the years of working with an ergonomically incorrect workstation. Her diagnoses are right shoulder pain, left shoulder pain, right greater than left wrist overuse injury, cervical strain with right upper extremity radiculopathy, and chronic adjustment disorder with mixed emotional features. She described the activities that aggravated her pain which were extreme typing, lifting and/or manipulating heavy objects. Prior treatment history has included medications including narcotics, physical therapy and cortisone injections. The patient underwent a right shoulder subacromial decompression on 02/27/2012. PR2 dated 10/10/2013 indicated the patient presented with complaints of persistent upper extremity complaints. She was doing well postoperatively. She had returned to work on modified duty. Her right shoulder continued to bother her, but overall she was doing better than she was prior to surgery. Objective findings on exam revealed mild acromioclavicular joint pain of the right shoulder. The biceps tendon was tender. On range of motion, active abduction to 180 degrees and passive abduction to 180 degrees; Impingement sign was negative. The treating provider has requested Tizanidine 4mg every 12 hours, # 120.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tizanidine 4mg, #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG Pain Chapter: Tizanadine; Muscle Relaxants

**Decision rationale:** Tizanidine ( Zanaflex) is a centrally acting alpha-2-adrenergic agent FDA approved for the treatment of spasticity; unlabeled use for low back pain. It is indicated for the treatment of chronic myofascial pain and as adjunct treatment for the treatment of fibromyalgia. Per California MTUS Guidelines muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory medications alone. The claimant has no reported cervical spasm on exam . Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.