

<b>Case Number:</b>	CM14-0216966		
<b>Date Assigned:</b>	01/02/2015	<b>Date of Injury:</b>	08/30/2009
<b>Decision Date:</b>	02/28/2015	<b>UR Denial Date:</b>	12/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/22/2014

### 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. 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 33 year old female with a date of injury of August 30, 2009. The results of the injury include right shoulder pain. Diagnosis include status post right shoulder surgery and right shoulder adhesive capsulitis and impingement syndrome. Treatment has included physical therapy, medications, and a right subacromial injection. Medical imaging was not provided, Progress report dated October 2, 2014 showed palpable tenderness over the AC and anterior and lateral aspect of the right shoulder. Range of motion was decreased. Disability status was noted as permanent and stationary. The treatment plan included 6 sessions of physical therapy to the right shoulder, to continue current medication, and follow up post physical therapy. Utilization Review form dated December 16, 2014 non certified Tizanidine HCL 4mg, 1 orally twice daily, not to exceed 2 in 24 hours due to noncompliance with MTUS guidelines recommendations.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tizanidine HCL 4mg, 1 orally twice daily, not to exceed 2 in 24 hours (prescribed 11/24/14): 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 Page(s): 66.

**Decision rationale:** According to the 11/24/2014 report, this patient is “doing quite well.” The current request is for Tizanidine HCL 4mg 1 orally twice daily, not to exceed 2 in 24 hours (prescribed 11/24/2014). The MTUS guidelines page 66, "Tizanidine (Zanaflex, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain." However, the MTUS guidelines for muscle relaxers only allow a short course of treatment (2-3 weeks) for acute muscle spasms. The documentation provided indicates that this prescription is for long term use which is not supported by MTUS. This medication was first noted in the 07/02/2014 report. The current request is not medically.