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| Case Number: | CM15-0118083 | | |
| Date Assigned: | 06/29/2015 | Date of Injury: | 02/11/2014 |
| Decision Date: | 08/28/2015 | UR Denial Date: | 06/15/2015 |
| Priority: | Standard | Application Received: | 06/19/2015 |

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 York

Certification(s)/Specialty: Anesthesiology

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 29 year old, female who sustained a work related injury on 2/11/14. The diagnoses have included right shoulder pain, likely right rotator cuff syndrome and cervical myofascial pain. Treatments have included medications, physical therapy, acupuncture, work modifications and psychotherapy. In the Workers' Compensation New Patient Consultation dated 3/20/15, the injured worker complains of chronic right shoulder and right hand pain. She rates her pain level an 8-9/10. She describes the pain as shooting, numbing and ants crawling. She is able to perform activities of daily living without assistance. She has tenderness to palpation of cervical spinous processes and right cervical paraspinal facet joints. She has tenderness along the right trapezius and rhomboid muscles. She has tenderness along the right anterior shoulder joint line. She has positive Hawkin's, Neer's and open can sign tests on the right. She is working with activity modifications. The treatment plan includes a prescription for Zanaflex.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zanaflex 4mg quantity 90 with three refills: 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 Muscle Relaxants Page(s): 63-66.

Decision rationale: Zanaflex (Tizanidine) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. It is indicated for the treatment of chronic myofascial pain and considered an adjunct treatment for fibromyalgia. According to CA MTUS Guidelines, muscle relaxants have not been considered any more effective than non-steroidal anti-inflammatory drugs (NSAIDs) for pain or overall improvement. There is no additional benefit shown in combination with NSAIDs. In addition, sedation is the most commonly reported adverse effect of muscle relaxant medications. In this case, there is no documentation of a maintained increase in function or decrease in pain with this medication. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.