

Case Number:	CM14-0036300		
Date Assigned:	06/25/2014	Date of Injury:	10/11/2011
Decision Date:	12/30/2014	UR Denial Date:	03/18/2014
Priority:	Standard	Application Received:	03/25/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 62-year-old female with a date of injury of 10/11/2011. According to progress report 03/04/2014, the patient presents with low back pain radiating down to the right leg. The patient rates her pain with medication as a 3/10, but without medications 5/10. The patient reports that medications are "working well." Current medication regimen includes meloxicam 7.5 mg, nortriptyline HCL 10 mg, hydrocodone/acetaminophen 5/500 mg, and Zanaflex 2 mg. MRI of the lumbar spine from 11/18/2013 revealed stenosis at L4-L5 and significant Modic changes at L5-S1 with severe degeneration. Examination of the lumbar spine revealed restrictive range of motion with flexion limited to 40 degrees, extension limited to 5 degrees, right lateral bending limited to 8 degrees, left lateral bending limited to 10 degrees, lateral rotation to the left limited to 40 degrees, and lateral rotation to the right limited to 40 degrees. On palpation of paravertebral muscle, spasm, tenderness, and tight muscle band is noted on the right side. Faber test is positive and there was tenderness noted over the sacroiliac spine. Listed diagnoses are: 1. Lumbar radiculopathy. 2. Low back pain. 3. Sacroiliitis drop foot using AFO and cane. The treater recommends refill of medications and states that the patient is taking current medications as prescribed and her symptoms persist, but they are alleviated somewhat by current medications. Utilization review denied the request on 03/18/2014. Treatment reports from 10/15/2013 through 03/04/2014 were provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Meloxicam 7.5MG #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxant.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines antiinflammatories Page(s): 22.

Decision rationale: This patient presents with chronic low back pain that radiates into the lower extremity. The current request is for meloxicam 7.5 mg #30. Meloxicam is an anti-inflammatory drug (NSAID). The MTUS Guidelines page 22 states anti-inflammatories are the traditional first line of treatment to reduce pain, so activity and functional restoration can resume, but long-term use may not be warranted. The utilization review denied the request stating that guidelines do not support ongoing chronic use of NSAIDs because of the propensity for GI and cardiovascular side effects. Review of the medical file indicates the patient has been utilizing meloxicam since 10/15/2013. Review of treatment reports indicates the patient has decreasing pain utilizing current medications which include meloxicam. Treater continually notes the patient's medications are working sufficiently in reducing patient's pain and patient denies any GI distress with taking this medication. Given the patient's chronic low back pain and treater's documentation of medication efficacy, the request is medically necessary.

Zanaflex 2MG #30: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxant.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants for pain Page(s): 66.

Decision rationale: This patient presents with chronic low back pain that radiates into the lower extremity. The current request is for Zanaflex 2 mg #30. MTUS Chronic Pain Medical Treatment Guidelines for Muscle Relaxants for pain, pg. 66:" Antispasticity/Antispasmodic Drugs: 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. One study (conducted only in females) demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain." Review of the medical file indicates the patient was first prescribed this medication on 10/15/2013 for "severe and frequent muscle spasms across the low back and right lower extremity." In this case, the patient suffers from chronic low back pain and radicular symptoms. The treater provides a before and after pain scale which notes a decrease in pain with current medication regimen which includes Zanaflex. Treater continually notes that medications sufficiently work in reducing pain. The request is medically necessary.