

<b>Case Number:</b>	CM14-0036893		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	06/26/2012
<b>Decision Date:</b>	07/25/2014	<b>UR Denial Date:</b>	02/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/26/2014

### 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 and Rehabilitation and is licensed to practice in Illinois. 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 injured worker is a 51 year old female with a reported injury on 06/26/2012. The mechanism of injury was not provided. The injured worker had an examination on 05/07/2014 with complaints of persistent left shoulder pain on scale of 3-4/10. She reported worsening while at work doing repetitive work with the left shoulder and arm. She reported taking acetaminophen and tramadol which improved her pain from a 4/10 to a 2/10. The exam showed left shoulder range of motion, flexion at 160 degrees, extension and adduction at 40 degrees, abduction at 140 degrees, internal rotation at 60 degrees, and external rotation at 70 degrees. Her strength was 4/5 in flexion and abduction. Her diagnoses consisted of left humerus shaft fracture status post intramedullary rod and chronic left shoulder pain and trapezial pain. The recommended treatment was to have physical therapy, continue Tramadol and kera-tek analgesic gel. There was no mention of Meloxicam in the physician report. The request for authorization and the rationale were not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Meloxicam 15 mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 70-73, 61.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (non-steroidal anti-inflammatory drugs) Page(s): 67-68.

**Decision rationale:** The request for Meloxicam 15 mg is not medically necessary. The injured worker complained of persistent shoulder pain. The Chronic Pain Medical Treatment Guidelines recommend the lowest dose of NSAIDs for the shortest period of time. The guidelines also state that there is no evidence to recommend one drug in the NSAID class over another based on efficacy. The guidelines also mention there is no evidence of long-term effectiveness for pain or function. The injured worker is already taking Acetaminophen and Tramadol with some benefit. Furthermore, the request does not specify directions of use, including quantity, frequency and duration. Therefore the request is not medically necessary.