

Case Number:	CM14-0093671		
Date Assigned:	09/12/2014	Date of Injury:	08/02/2010
Decision Date:	11/04/2014	UR Denial Date:	06/09/2014
Priority:	Standard	Application Received:	06/20/2014

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 Family Medicine and is licensed to practice in North Carolina. 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 37-year-old with a reported date of injury of 08/02/2010. The patient has the diagnoses of cervical disc disease, cervical radiculopathy, shoulder tendonitis with labral tear and cubital tunnel syndrome. Past treatment modalities have included physical therapy, cervical epidural steroid injections and shoulder surgery. Per the most recent progress notes provided for review by the treating physician dated 04/24/2014, the patient had complaints of continuing pain rated a 7/10 with hands feeling hot and swollen. The physical exam noted cervical paraspinal tenderness to palpation with restricted range of motion. The right shoulder had restricted range of motion with tenderness over the anterior subacromial joint and positive impingement sign. The right arm showed tenderness over the medial epicondyle, positive Tinel's sign, decreased sensation in the ulnar nerve distribution and restricted range of motion. The left arm noted the same exam as the right arm. Treatment plan recommendations included surgical evaluation for ulnar nerve entrapment, medication modification and home exercise program.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 retrospective request for Meloxicam 7.5 mg. # 120, DOS 2/27/14: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's (non-steroidal anti-inflammatory drugs) Page(s): Pages: 67.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 70-72.

Decision rationale: The California chronic pain medical treatment guideline section on NSAID therapy states: Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxen being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008) Meloxicam (Mobic, generic available): 7.5, 15 mg. Dosing: Osteoarthritis: The usual initial dose is 7.5 mg/day, although some patients may receive additional benefit with an increase to 15 mg a day. The maximum dose is 15 mg/day. Use for mild to moderate pain is off-label. (Mobic Package Insert) This medication is recommended at the lowest possible dose for the shortest period of time. The duration of "shortest period of time" is not defined in the California MTUS. The patient has no mentioned cardiovascular, renovascular or gastrointestinal side-effects or risk factors. The dosage prescribed is within recommendations. Therefore the request is medically necessary.

Retrospective request for Tizanidine 4 mg. # 180, DOS: 2/27/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): Pages: 63-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63-65.

Decision rationale: The California chronic pain medical treatment guidelines section on muscle relaxants states: Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) 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. (Malanga, 2008) Eight studies have demonstrated efficacy for low back pain. (Chou, 2007). The long term chronic use of this medication is not recommended per the California MTUS. The medication has not been prescribed for the acute flare up of chronic low back pain.

The patient does not have multiple sclerosis or spinal cord injury. The criteria set forth above for its use has not been met. Therefore the request is not medically necessary.

Meloxicam 7.5 mg. X # 120, DOS: 4/24/14: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's (Non-steroidal anti-inflammatory drug Page(s): Pages: 67-6.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 70-72.

Decision rationale: The California chronic pain medical treatment guideline section on NSAID therapy states:Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008). Meloxicam (Mobic, generic available): 7.5, 15 mg. Dosing: Osteoarthritis: The usual initial dose is 7.5 mg/day, although some patients may receive additional benefit with an increase to 15 mg a day. The maximum dose is 15 mg/day. Use for mild to moderate pain is off-label. (Mobic Package Insert). This medication is recommended at the lowest possible dose for the shortest period of time. The duration of "shortest period of time" is not defined in the California MTUS. The patient has no mentioned cardiovascular, renovascular or gastrointestinal side-effects or risk factors. The dosage prescribed is within recommendations. Therefore the request is medically necessary.

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improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004). 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. (Malanga, 2008) Eight studies have demonstrated efficacy for low back pain. (Chou, 2007) The long term chronic use of this medication is not recommended per the California MTUS. The medication has not been prescribed for the acute flare up of chronic low back pain. The patient does not have multiple sclerosis or spinal cord injury. The criteria set forth above for its use has not been met. Therefore the request is not medically necessary.