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| Case Number: | CM15-0044168 | | |
| Date Assigned: | 03/16/2015 | Date of Injury: | 12/27/1999 |
| Decision Date: | 04/17/2015 | UR Denial Date: | 03/04/2015 |
| Priority: | Standard | Application Received: | 03/09/2015 |

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 45 year old female who sustained an industrial injury on 12/27/99. The injured worker reported symptoms in the back. The injured worker was diagnosed as having left shoulder strain/sprain with tendonitis, impingement, right shoulder strain sprain with tendonitis, impingement, right and left wrist strain/sprain, electronegative carpal tunnel syndrome on the left, status post right carpal tunnel release, and cervical disk herniation with radiculitis/radiculopathy. Treatments to date have included ultrasound guided injection, anti-inflammatory medications, activity modifications, epidural injections, and oral pain medications. Currently, the injured worker complains of pain in the back and shoulders. The plan of care was for medication prescriptions and a follow up appointment at a later date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Meloxicam: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Meloxicam, NSAIDs Page(s): 61, 67-68.

Decision rationale: MTUS states "Meloxicam is a nonsteroidal anti-inflammatory drug (NSAID) for the relief of the signs and symptoms of osteoarthritis. See NSAIDs." MTUS guidelines for NSAIDs are divided into four usage categories: Osteoarthritis (including knee and hip), Back Pain- Acute exacerbations of chronic pain, Back Pain - Chronic low back pain, and Neuropathic pain. The treating physician has not specified a dosage or number of medication being requested. Guidelines recommend Meloxicam for short-term use. Without a specific request, the medication cannot be certified. As such, the request for Meloxicam is not medically necessary.