

Case Number:	CM14-0176265		
Date Assigned:	10/29/2014	Date of Injury:	09/11/2013
Decision Date:	12/15/2014	UR Denial Date:	10/14/2014
Priority:	Standard	Application Received:	10/24/2014

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 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:

According to the records made available for review, this is a 44-year-old female with a 9/11/13 date of injury. At the time (10/10/14) of Decision for Hydrocodone/APAP 10/325 MG #30, Orphenadrine Citrate 100 MG ER #60, and Ketoprofen 20 Percent, there is documentation of subjective (low back pain radiating to the bilateral lower extremities and left scapular pain) and objective (tenderness to palpitation over the thoracic and lumbar spine, decreased range of motion of the lumbar spine, decreased psoas muscle strength, and positive straight leg raise and Lasegue's test) findings, current diagnoses (thoracic sprain /strain, left scapular pain, and lumbar herniated nucleus pulposus with moderate to severe bilateral neural foraminal narrowing L4-L5), and treatment to date (chiropractic treatment, acupuncture, epidural steroid injection, and medications (including ongoing Norco, Orphenadrine, and Ketoprofen since at least 7/30/14)). Regarding Hydrocodone/APAP 10/325 MG #30, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Hydrocodone/APAP use to date. Regarding Orphenadrine Citrate 100 MG ER #60, there is no documentation of acute exacerbation of chronic low back pain; short-term (less than two weeks) treatment; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Orphenadrine use to date. Regarding Ketoprofen 20 Percent, there is no documentation that trials of antidepressants and anticonvulsants have failed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/APAP 10/325 MG #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80. Decision based on Non-MTUS Citation Title 8, California Code of Regulations,

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of thoracic sprain /strain, left scapular pain, and lumbar herniated nucleus pulposus with moderate to severe bilateral neural foraminal narrowing L4-L5. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, given documentation of ongoing treatment with Hydrocodone/APAP, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Hydrocodone/APAP use to date. Therefore, based on guidelines and a review of the evidence, the request for Hydrocodone/ APAP 10/325 MG #30 is not medically necessary.

Orphenadrine Citrate 100 MG ER #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63-64. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain) Title 8, California Code of Regulations

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of acute exacerbation of chronic low back pain and used as a second line option for short-term treatment, as criteria necessary to support the medical necessity of muscle relaxant. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended for short-term (less than two weeks) treatment. Within the medical information available for review, there is documentation of diagnoses of

thoracic sprain /strain, left scapular pain, and lumbar herniated nucleus pulposus with moderate to severe bilateral neural foraminal narrowing L4-L5. In addition, there is documentation of ongoing treatment with Orphenadrine and Orphenadrine used as a second line option. However, despite documentation of low back pain, and given documentation of a 9/11/13 date of injury, there is no documentation of acute muscle spasms, or acute exacerbation of chronic low back pain. In addition, given documentation of records reflecting prescriptions for Orphenadrine Citrate since at least 7/30/14, there is no documentation of the intention to treat over a short course (less than two weeks). Furthermore, given documentation of ongoing treatment with Orphenadrine Citrate ER, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Orphenadrine use to date. Therefore, based on guidelines and review of the evidence, the request for Orphenadrine Citrate 100 MG ER #60 is not medically necessary.

Ketoprofen 20 Percent: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Within the medical information available for review, there is documentation of diagnoses of thoracic sprain /strain, left scapular pain, and lumbar herniated nucleus pulposus with moderate to severe bilateral neural foraminal narrowing L4-L5. In addition, there is documentation of neuropathic pain. However, there is no documentation that trials of antidepressants and anticonvulsants have failed. Therefore, based on guidelines and a review of the evidence, the request for Ketoprofen 20 Percent is not medically necessary.