

<b>Case Number:</b>	CM14-0064853		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	08/12/2011
<b>Decision Date:</b>	09/17/2014	<b>UR Denial Date:</b>	04/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/07/2014

### 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 Pain Medicine 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 injured worker is a 51-year-old female who reported an injury on 08/12/2011. The mechanism of injury occurred when the injured worker was lifting a box of trays and injured her upper and lower back. The injured worker had a history of lower back pain and right lower extremity symptoms. The diagnoses included lumbar stenosis, anterolisthesis grade 1 at the L4-5, degenerative disc disease with facet arthropathy, chronic endplate compression at the T12, and herniated nucleus pulposus lumbar spine. The magnetic resonance imaging (MRI) of the lumbar spine dated 11/12/2012 revealed degenerative disc disease, facet arthropathy with postoperative changes at the L5-S1 with a grade 1 anterolisthesis at the L4-5, mild canal stenosis noted at the L4-5, chronic superior endplate compression at the T12 vertebral body. The diagnostics included an x-ray dated 11/12/2012 of the lumbar spine that revealed grade 1 anterolisthesis at the L4-5 that was stable. Disc space narrowing noted at the L5-S1. The medications included Hydrocodone/APAP 7.5/325 mg, Norflex ER 100 mg, Omeprazole 20 mg, Ketoprofen 75 mg, and Orphenadrine Citrate 100 mg. The past treatments included an epidural steroid injection. The objective findings dated 04/08/2014 to the lumbar spine revealed well-healed incision, range of motion decreased to all planes with associated pain with extension. Tenderness to palpation midline over the anterior inversion and plantarflexion and eversion were 4+/5, positive straight leg raise to the right. The treatments included physical therapy, chiropractic, psychotherapy, multiple pain management modalities, injections, surgery, and exercise. The Request for Authorization dated 07/11/2014 was submitted with documentation. The rationale for the medications was not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**60 tablets of Orphenadrine Citrate 100mg: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASMODICS Page(s): 64-65.

**Decision rationale:** The request for 60 tablets of Orphenadrine Citrate 100 mg is not medically necessary. The California MTUS indicate that Orphenadrine is used to decrease muscle spasm in conditions such as low back pain, although it appears that these medications are often used for the treatment of musculoskeletal conditions whether spasm is present or not. The mechanism of action for most of these agents is not known. Orphenadrine is similar to diphenhydramine, but has greater anticholinergic effects. The mode of action is not clearly understood. Effects are thought to be secondary to analgesic and anticholinergic properties. The guidelines indicate that Orphenadrine is similar to diphenhydramine. The mechanism of action for most of these agents is unknown. The request did not indicate the frequency. As such, the request is not medically necessary.

**90 capsules of Ketoprofen 75mg: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 11-112.

**Decision rationale:** The request for 90 capsules of Ketoprofen 75 mg is not medically necessary. The CA MTUS states Ketoprofen is a Non FDA-approved agent. This agent is not currently FDA approved for a topical application. It has an extremely high incidence of photo-contact dermatitis. The guidelines do not recommend the Ketoprofen. The request did not address the frequency. As such, the request is not medically necessary.

**60 tablets of Hydrocodone/APAP 10/325mg: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management of Hydrocodone/Acetaminophen Page(s): 78, 91.

**Decision rationale:** The request for 60 tablets of Hydrocodone/APAP 10/325mg is not medically necessary. The CA MTUS states Hydrocodone/Acetaminophen is indicated for moderate to moderately severe pain and there should be documentation of the 4 A's for Ongoing

Monitoring including analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. As such, the request is not medically necessary.

**60 capsules of Omeprazole 20mg: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Specific Drug List & Adverse Effects) Page(s): 70.

**Decision rationale:** The request for 60 capsules of Omeprazole 20 mg is not medically necessary. The California MTUS recommends proton pump inhibitors for the treatment of dyspepsia secondary to NSAID therapy. There has been a recommendation to measure liver transaminases within 4 to 8 weeks after starting therapy, but the interval of repeating lab tests after this treatment duration has not been established. Routine blood pressure monitoring is recommended. The documentation was not evident that the injured worker had a peptic ulcer or gastrointestinal issues. The request did not address the frequency. As such, the request is not medically necessary.