

Case Number:	CM14-0078172		
Date Assigned:	07/18/2014	Date of Injury:	03/02/2009
Decision Date:	09/29/2014	UR Denial Date:	05/13/2014
Priority:	Standard	Application Received:	05/28/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida and Texas. 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 30 year old who was injured on 2/3/2009. The diagnoses are lumbar radiculopathy, failed back syndrome and lumbar spinal stenosis. The patient completed 18 physical therapy sessions, epidural steroid injections and spinal cord stimulator implantation. On 5/8/2014, [REDACTED] noted subjective complaints of low back pain moderately decreased by the use of spinal cord stimulator and medications. The provider discussed a reduction of medication use after implantation of the spinal cord stimulator. The medications are Hydrocodone and Relafen for pain, Orphenadrine for muscle spasm and Cetirizine for unstated indication. A Utilization Review determination was rendered on 5/13/2014 Cetirizine 10mg #30, Relafen 750mg #60, Orphenadrine 100mg #60 and Hydrocodone/APAP 10/325mg #90.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cetirizine HCL 10mg# 30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/cetirizine-hcl.html>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

Decision rationale: The CA MTUS and the ODG guidelines do not recommend the chronic use of antihistamines for the treatment of opioids induced side effects. The nausea, vomiting or itching associated with opioids treatment is self-limiting and will respond to dose reduction. The records indicate that the patient have been on chronic Certrizine treatment. The criterion for the use of Certrizine 10mg #30 was not met, therefore, the request is not medically necessary.

Relafen 760mg #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

Decision rationale: The CA MTUS recommends that NSAIDs can be utilized during exacerbation of chronic musculoskeletal pain. The records indicate that the patient is experiencing increase in pain intensity despite the use of spinal cord stimulator, physical therapy and medications. The criterion for the use of Relafen750mg #60 was met and is medically necessary.

Orphenadrine 100 mg # 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 Page(s): 63-66.

Decision rationale: The CA MTUS recommends that the use of muscle relaxants be limited to short term periods to minimize the development of addiction, dependency, tolerance and drug interactions associated with chronic use of sedative muscle relaxants. The records indicate that the patient has been utilizing Orphenadrine longer than the recommended 4 weeks period. The criterion for the use of Orphenadrine 100mg #60 was not met, therefore, the request is not medically necessary.

Hydrocodone 10/325mg # 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, NSAIDs and Physical Therapy Page(s): 74-96.

Decision rationale: The CA MTUS recommends that opioids could be utilized for the treatment of exacerbations of chronic pain that is non-responsive to standard treatment with NSAIDs and physical therapy. The records indicate that the provider had discussed opioid reduction with the

patient after implantation of the spinal cord stimulator. The patient can discontinue opioid utilization when the current increase in pain has resolved with the use of NSAIDs and spinal cord stimulator treatment. The criteria for the use of Hydrocodone/APAP 10/325mg #90 was not met, therefore, the request is not medically necessary.