

Case Number:	CM14-0099889		
Date Assigned:	09/16/2014	Date of Injury:	08/10/2011
Decision Date:	11/13/2014	UR Denial Date:	05/24/2014
Priority:	Standard	Application Received:	06/30/2014

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, 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 38-year-old female with an 8/10/11 date of injury. At the time (5/14/14) of request for authorization for Orphenadrine-Norflex ER 100 mg #90, Nabumetone 500 mg #90, Hydrocodone 10/325 mg #30, and Ketamine 5% cream 60 gram, there is documentation of subjective (chronic neck and right upper extremity pain) and objective (antalgic gait, tenderness over cervical spine as well as right upper trapezius muscle, and decreased cervical range of motion) findings, current diagnoses (cervical degenerative disc disease), and treatment to date (medications (including ongoing treatment with Cyclobenzaprine, Nabumetone, Hydrocodone 10/325 mg, Ketamine cream, Terocin patch, and Tylenol)). Medical report identifies that medications (Hydrocodone 10/325 mg, Nabumetone, and Ketamine cream) help decrease pain and maintain function. Regarding Orphenadrine-Norflex ER 100 mg #90, there is no documentation of acute exacerbation of chronic low back pain; and an intention for short-term (less than two weeks) treatment. Regarding Nabumetone 500 mg #90, there is no (clear) 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 Nabumetone use to date. Regarding Hydrocodone 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 10/325 mg use to date. Regarding Ketamine 5% cream 60 gram, there is no documentation of neuropathic pain in which all primary and secondary options have been exhausted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orphenadrine-Norflex ER 100 mg #90: 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)

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. 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 a diagnosis of cervical degenerative disc disease. In addition, there is documentation of Orphenadrine-Norflex used as a second line option. However, given documentation of chronic pain, and an 8/10/11 date of injury, there is no documentation of acute muscle spasm, or acute exacerbation of chronic low back pain. In addition, given documentation of a request for Orphenadrine-Norflex ER 100 mg #90, there is no (clear) documentation of an intention for short-term (less than two weeks) treatment. Therefore, based on guidelines and a review of the evidence, the request for Orphenadrine-Norflex ER 100 mg #90 is not medically necessary.

Nabumetone 500 mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe osteoarthritis pain, acute low back pain, chronic low back pain, or exacerbations of chronic pain, as criteria necessary to support the medical necessity of NSAIDs. 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 service. Within the medical information available for review, there is documentation of a diagnosis of cervical degenerative disc disease. In addition, there is documentation of ongoing treatment with Nabumetone for pain. However, despite documentation that medications (Hydrocodone 10/325 mg, Nabumetone, and Ketamine cream) help decrease pain and maintain function, there is no (clear) 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 specifically as a result of Nabumetone use to date. Therefore, based on the guidelines and review of the evidence, the request for Nabumetone 500 mg #90 is not medically necessary.

Hydrocodone 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 Other Medical Treatment Guideline or Medical Evidence: 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 a diagnosis of cervical degenerative disc disease. In addition, there is documentation of ongoing treatment with Hydrocodone 10/325 mg. 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, despite documentation that medications (Hydrocodone 10/325 mg, Nabumetone, and Ketamine cream) help decrease pain and maintain function, there is no (clear) 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 specifically as a result of Hydrocodone 10/325 mg use to date. Therefore, based on guidelines and a review of the evidence, the request for Hydrocodone 10/325 mg #30 is not medically necessary.

Ketamine 5% cream 60 gram: 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): 113.

Decision rationale: MTUS Chronic Pain Medical Treatment guidelines identify documentation of neuropathic pain when all primary and secondary options have been exhausted, as criteria necessary to support the medical necessity of Topical Ketamine. Within the medical information available for review, there is documentation of a diagnosis of cervical degenerative disc disease. In addition, there is documentation of ongoing treatment with Ketamine cream. However, there

is no documentation of neuropathic pain in which all primary and secondary options have been exhausted. Therefore, based on guidelines and a review of the evidence, the request for Ketamine 5% cream 60 gram is not medically necessary.