

Case Number:	CM14-0182042		
Date Assigned:	11/06/2014	Date of Injury:	02/14/2002
Decision Date:	01/16/2015	UR Denial Date:	10/10/2014
Priority:	Standard	Application Received:	11/03/2014

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 Family Medicine, and is licensed to practice in Utah. 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 46 year-old male. The patient's date of injury is 5/1/1997 or 2/14/2002, both are stated. The mechanism of injury was described as back pain while working with lifting cabinets. The patient has been diagnosed with low back pain, radicular type. The patient's treatments have included a low back brace, chiropractic adjustments, physical therapy, imaging studies, EMG's and medications. The physical exam findings dated October 14, 2003 shows he walks with a normal gait. The lumbar spine was reported with a decreased flexion. The patellar reflexes were absent and very difficult to obtain, as well as the Achilles reflexes. The right extensor hallucis longus is noted as weak with and 5/5 on the right. The patient's medications have included, but are not limited to, Vicodin, Omeprazole, Orphenadrine, Ambien, Soma and Naproxen. The request is for Diclofenac, Orphenadrine, Hydrocodone/APAP and Ambien.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Prescription of Diclofenac Sodium ER 100mg #60: 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): 71.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Diclofenac 100 mg twice daily. MTUS guidelines state the following: Dosages > 150 mg/day PO are not recommended. Diclofenac at the current dosage exceeds the current recommended dosage. According to the clinical documentation provided and current MTUS guidelines; Diclofenac, as written above, is not indicated as a medical necessity to the patient at this time.

1 Prescription of Orphenadrine 100mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: MTUS guidelines state the following: Orphenadrine is indicated for as an option for use in short course of therapy. Efficacy is greatest in the first four days of treatment with this medication. MTUS states that treatment course should be brief. According to the clinical documents, the Orphenadrine requested is not being used for short term therapy, as the patient has been taking it since at least April 2014. Following guidelines as listed above, there is no indication for the use of Orphenadrine. At this time, the request is not deemed as a medical necessity.

1 Prescription of Hydrocodone/APAP 10/325mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 75-79.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. According to the clinical records, the patient was taking this medication since 2012. There is no clear functional gain that has been documented with this medication. In addition, according to the documentation provided, there has been no significant change in character of the pain; the pain appears to be chronic, lacking indications for fast acting pain control medications. According to the clinical documentation provided and current MTUS guidelines; Hydrocodone/APAP, is not indicated a medical necessity to the patient at this time.

1 Prescription of Ambien 10mg#30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) , ODG, Ambien

Decision rationale: MTUS treatment guidelines are silent about Ambien. Other guidelines were used in this review. ODG guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Ambien. Guidelines state the following: recommends Ambien for short term use, usually two to six weeks) for treatment of insomnia. There is concern for habit forming, impaired function and memory, as well as increased pain and depression over long term. According to the clinical documentation provided and current guidelines; this medications has been longer than 6 weeks. Ambien, as written above, is not indicated as a medical necessity to the patient at this time.