

Case Number:	CM14-0207906		
Date Assigned:	12/19/2014	Date of Injury:	10/02/2013
Decision Date:	02/18/2015	UR Denial Date:	11/13/2014
Priority:	Standard	Application Received:	12/12/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 man who sustained a work-related injury on October 2, 2013. Subsequently, he developed chronic low back pain. According to a visit note dated November 3, 2014, the patient complained of ongoing left lower and left middle back pain. The patient rated his level of pain as a 5/10. The patient has been approved for epidural steroid injection. The note did not document the presence of any acute exacerbation of pain or myospasm or breakthrough pain or myospasm. A visit note dated October 6, 2014 noted no scoliosis, asymmetry or abnormal curvature on inspection of the lumbar spine. No limitation in range of motion was noted. Lumbar facet loading was positive on both sides. Stretch of the piriformis was negative. Straight leg raising was positive on the left side in supine position at degrees. FABER test was negative. All lower extremity reflexes were equal and symmetric. The recent UDS was documented as appropriate. The patient was diagnosed with lumbar disc degeneration. The provider requested authorization for Orphenadrine and Voltaren.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orphenadrine 100mg #60 refill: 2: 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; Antispasticity Drugs Page(s): 63; 66.

Decision rationale: According to MTUS guideline, Orphenadrine (Norflex , Banflex , Antiflex, Mio-Rel, Orphenate, generic) is a muscle relaxant with anticholinergic effects. MTUS guidelines stated that a non-sedating muscle relaxants is recommended with caution as a second line option for short term treatment of acute exacerbations in patients with chronic lumbosacral pain. Efficacy appears to diminish over time and prolonged use may cause dependence. The patient in this case does not have clear and recent evidence of acute exacerbation of spasm. The request of Orphenadrine 100 mg #60 with 2 refills is not medically necessary.

Voltaren -XR 100 mg #30 refill: 2: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-selective NSAIDs Page(s): 107.

Decision rationale: According to MTUS guidelines, Diclofenac Sodium ER is used for osteoarthritis pain. There is no documentation of the efficacy of previous use of the drug. There is no documentation of monitoring for safety and adverse reactions of the drug. There is no documentation that the patient developed osteoarthritis. Therefore, the request for Diclofenac Sodium ER (Voltaren) 100mg Qty: 30 with 2 refills is not medically necessary.