

Case Number:	CM14-0098466		
Date Assigned:	07/28/2014	Date of Injury:	08/10/2011
Decision Date:	10/08/2014	UR Denial Date:	05/27/2014
Priority:	Standard	Application Received:	06/26/2014

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 Occupational 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 patient is a 38 year-old female with date of injury 08/10/2011. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 05/14/2014, lists subjective complaints as chronic neck and bilateral upper extremity pain. Objective findings: tenderness to palpation was noted along the cervical paraspinal region bilaterally. Myofascial spasms, guarding and tension was noted in the bilateral upper trapezius region. Range of motion of cervical spine was intact for flexion and extension, but reduced to 20 degrees lateral bending bilaterally. Motor strength was 4/5 with bilateral elbow extension. Sensation was reduced in right C6 and C8 dermatomes when compared to the left. Negative Spurling's bilaterally. Diagnoses are degenerative disc disease at C4-5 and C5-6, neck pain, and pain in shoulder joint. The medical records supplied for review document that the patient has been taking the following medications for at least as far back as two months. Medications include Orphenadrine- Norflex ER 100mg, #90 SIG: take 1 tab every 12 hours, Nabumetone 500mg, #90 SIG: 1 tablet every 12 hours, Hydrocodone 10/325mg, #60 SIG: 1 tab per day, and Ketamine 5% Cream 60gm SIG: apply to affected area three times a day.

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 Page(s): 63, 65.

Decision rationale: Orphenadrine is an anticholinergic drug of the ethanalamine antihistamine class with prominent central nervous system (CNS) and peripheral actions used to treat painful muscle spasms and other similar conditions, as well as the treatment of some aspects of Parkinson's disease. The MTUS states that muscle relaxants are recommended with caution only on a short-term basis. The patient has been taking Orphenadrine for longer than the recommended 2-3 weeks by the MTUS. Therefore, this request 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 Page(s): 71-72.

Decision rationale: Nabumetone (Relafen) is an NSAID typically prescribed for osteoarthritis. The MTUS recommends that NSAIDs be used at the lowest dose for the shortest period in patients with moderate to severe pain. The patient has been taking Relafen for at least 2 months. The medical record fails to provide documentation of objective functional improvement from taking Nabumetone. Therefore, this request is not medically necessary.

Hydrocodone 10-325 mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-94.

Decision rationale: A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of narcotic. The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of narcotics, the patient has reported very little functional improvement or pain relief over the course of the last 2 months. Therefore, this request is not medically necessary.

Ketamine 5% Cream 60 GR: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56.

Decision rationale: The MTUS states that Ketamine is not recommended and that there is insufficient evidence to support the use of Ketamine for the treatment of chronic pain. There are no quality studies that support the use of Ketamine for chronic pain. Therefore, this request is not medically necessary.