

Case Number:	CM14-0092596		
Date Assigned:	07/25/2014	Date of Injury:	05/03/2001
Decision Date:	06/09/2015	UR Denial Date:	05/20/2014
Priority:	Standard	Application Received:	06/18/2014

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: Texas, California
 Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 54 year old male patient who sustained an industrial injury on 5/3/2001. Diagnoses include lumbago. Per the doctor's note dated 5/7/2015, he had complaints of chronic low back pain with intermittent radiation to lower extremities. The physical examination revealed antalgic gait. Per the physician notes dated 3/31/2014 he had complaints of low back pain rated 5-6/10 with medications and 10/10 without medications. The medications list includes Protonix, Hydrocodone/bit/Acetaminophen, Norflex and sonata. He has had lumbar MRI on 8/1/2008; cervical MRI on 11/17/13 and CT cervical spine on 6/11/13; EMG lower extremities on 11/19/2008. He has undergone lumbar surgery and cervical spine surgery. He has had physical therapy visits and TENS for this injury. He has had last urine drug screen on 3/12/15 and 11/20/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone/APAP 5/325mg, #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-80.

Decision rationale: Request: Hydrocodone/APAP 5/325mg, #180 Hydrocodone is an opioid analgesic. According to the cited guidelines, "A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals. The records provided do not specify that that patient has set goals regarding the use of opioid analgesic. The treatment failure with non-opioid analgesics is not specified in the records provided." Other criteria for ongoing management of opioids are: The lowest possible dose should be prescribed to improve pain and function. Continuing review of overall situation with regard to nonopioid means of pain control. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs. The records provided do not provide a documentation of response in regards to pain control and objective functional improvement to opioid analgesic for this patient. The continued review of the overall situation with regard to non-opioid means of pain control is not documented in the records provided. Response to lower potency opioid for chronic pain is not specified in the records provided. A recent urine drug screen report is not specified in the records provided. This patient does not meet criteria for ongoing continued use of opioids analgesic. The medical necessity of Hydrocodone/APAP 5/325mg, #180 is not established for this patient.

Orphanadrine ER 100mg, #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 (for pain), Page 63 Orphenadrine (Norflex, Banflex, Antiflex, Mio-Rel, Orphenate, generic available) page 65.

Decision rationale: Request: Orphanadrine ER 100mg, #60 Orphenadrine is antispasmodic. Per the cited guidelines,"it is used to decrease muscle spasm in conditions such as LBP for a short period of time." According to the cited guidelines, this drug is similar to diphenhydramine, but has greater anticholinergic effects. The mode of action is not clearly understood. Effects are thought to be secondary to analgesic and anti cholinergic properties. Per the cited guidelines, regarding muscle relaxants, "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP." Muscle relaxants are recommended for a short period of time. The patient has had chronic low back pain. Response to NSAIDs(first line option), without second line options like muscle relaxants, is not specified in the records provided. Response to pain with and without orphenadrine is not specified in the records provided. Evidence of muscle spasm or acute exacerbations is not specified in the records provided. The medical necessity of Orphanadrine ER 100mg, #60 is not fully established for this patient at this time.

