

Case Number:	CM15-0079590		
Date Assigned:	04/30/2015	Date of Injury:	04/03/2008
Decision Date:	06/04/2015	UR Denial Date:	04/03/2015
Priority:	Standard	Application Received:	04/25/2015

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 York
 Certification(s)/Specialty: Emergency 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 injured worker is a 41-year-old male, with a reported date of injury of 04/03/2006. The diagnoses include low back pain, and postlaminectomy lumbar syndrome. Treatments to date have included lumbar laminectomy, and psychological treatments. The progress report dated 03/11/2015 indicates that the injured worker continued to have low back pain with radiation to the right leg. There was also a pulling sensation with walking and increased pain with activity. It was noted that the injured worker was doing well on his current medication. The injured worker rated his pain 5 out of 10, with medications and 7 out of 10 without medications. The objective findings include a slightly antalgic gait, pain with range of motion of the lumbar spine, limited lumbar range of motion, and normal bilateral lower extremity reflexes and sensation. Current work status was not documented on this date. On 4/3/2015 Utilization Review certified requests for Orphenadrine citrate ER, modified Escitalopram, Norco, and non-certified requests for refills Escitalopram, Meloxicam with refills, and Orphenadrine citrate ER refills. CA MTUS chronic pain guidelines were used in support of these decisions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Escitalopram 10 MG #30 with 2 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Selective Serotonin Reuptake Inhibitors Page(s): 107-108.

Decision rationale: Escitalopram is a selective serotonin reuptake inhibitor (SSRI). According to MTUS guidelines, SSRIs are not recommended for the treatment of chronic pain. They do have a role treating secondary depression. The included records do not include the diagnosis for which this medication is being prescribed. Documentation does include records from psychotherapy visits. The diagnoses outlined in these therapy visits do not include depression. The record does not support this medication is being prescribed in accordance with MTUS guidelines. Without this, the request for escitalopram is not medically necessary.

Meloxicam 15 MG #30 with 2 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroid anti-inflammatory agents Page(s): 65-66.

Decision rationale: According to CA MTUS chronic pain guidelines, non-steroidal anti-inflammatory agents are "recommended as an option for short term symptomatic relief" for the treatment of chronic low back pain. Further recommendations are for the lowest dose for a minimal duration of time. The IW has been taking this medication for a minimum of 6 months per documentation. The documentation does not support improvement of symptoms with NSAIDs currently prescribed. The IW reports minimal pain relief with his current regimen. Additionally, the request does include frequency and dosing of this medication. The request for Meloxicam is medically not necessary.

Norco 10/325 MG #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Narcotic Page(s): 80-81, 86.

Decision rationale: CA MTUS, chronic pain guidelines, offer very specific guidelines for the ongoing use of narcotic pain medication to treat chronic pain. These recommendations state that the lowest possible dose be used as well as "ongoing review and documentation of pain relief, functional status, appropriate medication use and its side effects." It also recommends that providers of opiate medication document the injured worker's response to pain medication including the duration of symptomatic relief, functional improvements, and the level of pain relief with the medications. The included documentation fails to include the above-

recommended documentation. The IW has been on this medication for a minimum of 6 months. The IW reports mild improvement of pain with current medication regimen. In addition, the request does not include dosing frequency or duration. The request for Norco is not medically necessary.

Orphenadrine Citrate ER 100 MG #60 with 2 Refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxant Page(s): 63-65.

Decision rationale: According to CA MTUS, muscle relaxants are recommended as an option for short course of therapy. Effect is noted to be modest and is greatest in the first 4 days of treatment. Ophenadrine is categorized as a muscle relaxant with effects similar to diphenhydramine according to MTUS. The IW has been receiving this prescription for a minimum of 6 months according to submitted records. This greatly exceeds the recommended timeframe of treatment. In addition, the request does not include dosing frequency or duration. The request is not medically necessary.