

Case Number:	CM14-0104082		
Date Assigned:	07/30/2014	Date of Injury:	06/14/2007
Decision Date:	09/09/2014	UR Denial Date:	06/20/2014
Priority:	Standard	Application Received:	07/07/2014

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 Physical Medicine & Rehabilitation and is licensed to practice in Texas and Ohio 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 injured worker is a 69-year-old male who reported an injury on 06/14/2007. The documentation provided does not indicate a mechanism of injury. His diagnosis was noted to be facet osteoarthropathy. Prior treatments were noted to be medications. Pertinent diagnostics were noted to be an MRI of the lumbosacral spine. The injured worker was noted to have a surgical history of coronary artery bypass surgery. The injured worker had a clinical evaluation on 03/06/2014 with subjective complaints of low back pain, rated a 9/10. The injured worker also complained of compensatory right shoulder/cervical pain to which use of cane was attributed. The objective findings were noted to be tenderness in the lumbar spine region. Lumbar range of motion was limited. The treatment plan was to continue over the counter ibuprofen and use of tramadol. The provider's rationale for the request and the request for authorization form were not provided within the documentation submitted for review. Relevant medications were noted to be NSAIDS and a proton pump inhibitor.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro: Orphenadrine 100MG #90 DOS 5/12/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASMODICS Page(s): 64-65.

Decision rationale: The request for orphenadrine 100 mg quantity 90, date of service 05/12/2014, is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines state orphenadrine is a drug similar to diphenhydramine, but has greater anticholinergic effects. The port of action is not clearly understood. Effects are thought to be secondary to analgesic and anticholinergic properties. It is also noted within the guidelines, anticholinergic effects (drowsiness, urinary retention, dry mouth). These effects may limit use in the elderly. This medication has been reported in case studies to be abused for euphoria and to have mood elevating effects. The clinical documentation submitted for review does not indicate an adequate pain assessment. It is not noted that the injured worker has spasms. In addition, the provider's request fails to indicate a dosage frequency. Therefore, the request for retrospective orphenadrine 100 mg quantity 90, date of service 05/12/2014, is not medically necessary.