

<b>Case Number:</b>	CM15-0134889		
<b>Date Assigned:</b>	07/23/2015	<b>Date of Injury:</b>	07/31/2012
<b>Decision Date:</b>	09/22/2015	<b>UR Denial Date:</b>	06/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/13/2015

### 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: California, North Carolina  
 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:

The injured worker is a 34 year old male, who sustained an industrial injury on 07/31/2012 when he reported injuring his lumbar spine. The injured worker is currently temporarily totally disabled but recently was working with modifications. The injured worker is currently diagnosed as having displacement of lumbar intervertebral disc without myelopathy, sciatica, low back pain, and lumbar sprain. Treatment and diagnostics to date has included physical therapy, epidural steroid injections, lumbar spine MRI dated 03/10/2015, which showed new annular tear, mild disc bulging, and foraminal narrowing, and use of medications. In a progress note dated 05/21/2015, the injured worker presented with complaints of increased pain over the last few weeks with new left sided back pain. Objective findings include decreased sensation of knee and medial leg and positive straight leg raise test. The treating physician reported requesting authorization for Orphenadrine, Tramadol, and Anaprox DS.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Orphenadrine ER 100mg #60 with 2 refills:** 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 Page(s): 63-66.

**Decision rationale:** Orphenadrine is a skeletal muscle relaxant recommended for short-term use (2-3 weeks) and for acute exacerbations. Evidence shows that the greatest benefit is in the first 4 days of use. Muscle spasms should be documented to warrant the use of this medication. In this case, no muscle spasms are documented. In addition, the patient has been taking the medication since at least 4/10/2015, far exceeding recommended guidelines. Further, a lack of efficacy of the medication is also documented. Therefore the request is deemed not medically necessary or appropriate.

**Tramadol 50mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80, 93-94.

**Decision rationale:** CA MTUS Guidelines state that Tramadol is a synthetic opioid used for moderate to severe neuropathic pain. It is not recommended as a first-line agent. In this case, the patient's pain levels have not been objectively recorded. There is also a lack of efficacy documented since beginning the Tramadol on at least 4/10/2015. No urine drug screens are documented in the records, as required by guidelines. Therefore, this request for Tramadol is deemed not medically necessary or appropriate.

**Anaprox DS 550gm #60 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non-Steroidal Anti-Inflammatory Drugs (NSAIDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

**Decision rationale:** CA MTUS states that NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. There is no evidence for long-term effectiveness for pain or function with the use of NSAIDs. In this case, the patients has been treated with Anaprox since at least 4/10/2015 without documentation of efficacy or improvement in function. Therefore, the request for continued Anaprox is not medically necessary or appropriate.