

Case Number:	CM14-0209105		
Date Assigned:	12/22/2014	Date of Injury:	03/18/2008
Decision Date:	02/18/2015	UR Denial Date:	12/10/2014
Priority:	Standard	Application Received:	12/15/2014

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: California
 Certification(s)/Specialty: Internal 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 patient is an injured worker with a history of chronic low back pain. Date of injury was March 18, 2008. The progress report dated October 28, 2014 documented subjective complaints of low back pain as well as pain that radiates into his left leg and also states that as of recent he has had some pain higher up in his back. On physical examination, there is tenderness to palpation about the upper thoracic paraspinal musculature that translates down into the lumbar paraspinal musculature bilaterally. Active voluntary range of motion of the thoracolumbar spine was limited. The patient was able to forward flex to approximately 45 degrees and extend to 10 degrees before experiencing low back pain. Lateral bending was limited to 15 degrees in either direction. He was able to perform the heel and toe walk across the examination room; however, this maneuver produces a left antalgic gait. The straight-leg-raising test was positive on the left, negative on the right. Motor examination was felt to be normal in all major muscle groups of the lower extremities. Sensory examination was normal to light touch. Quadriceps reflexes were 1-2+ and symmetrical. Achilles' reflexes were 0-1+ and symmetrical. No pathologic reflexes were evident. Given that he appears to be experiencing pain higher up in his back, an x-ray of the thoracic spine was performed in the AP and lateral views. His x-ray is unremarkable for any significant findings. There is no fractures, no deformity, and no abnormal findings. The patient does appear to be having quite a bit of spasm about his low back and he was provided with a trigger point injection in multiple areas to reduce the spasm and inflammation. The patient exhibited a discrete focal tenderness located in a palpable taut band of skeletal muscle, which produced a local twitch in response to pressure against the band. The patient has developed a

myofascial pain syndrome with a direct relationship between the specific trigger points and its associated pain region. After obtaining a complete informed consent, under sterile technique, a local anesthetic, combined with Decadron, and ketorolac was injected directly into the trigger point. The ketorolac will allow immediate reduction in pain with the secondary medications allowing further resolution of pain over the next several hours to several days. The patient tolerated the procedure well and it was without any known complications. He will continue receiving his pain medication from his pain management specialist; however, he was provided with a muscle relaxant in the form of Orphenadrine and he was also provided with Lexapro for his continued depression. He was also provided with a written prescription for Voltaren gel to use as a topical anti-inflammatory. The patient remained permanent and stationary at this time.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoralac: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for trigger point injections Page(s): 123.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 309, Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) Trigger point injections (TPIs).

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses trigger point injections. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints (Page 300) indicates that trigger-point injections are not recommended. Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Table 12-8 Summary of Recommendations for Evaluating and Managing Low Back Complaints (Page 309) indicates that trigger-point injections are not recommended. Official Disability Guidelines (ODG) indicates that trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. The progress report dated October 28, 2014 documented the performance of trigger point injections to the low back. A local anesthetic combined with Ketorolac and Decadron was injected directly into the trigger point. ACOEM guidelines indicates that trigger-point injections are not recommended for low back conditions. The trigger point injection with Ketorolac and Decadron to the low back is not supported by ACOEM guidelines. Therefore, the request for Ketorolac is not medically necessary.

Orphenadrine ER 100mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-49, Chronic Pain Treatment Guidelines Orphenadrine (Norflex) Muscle

relaxants Page(s): 65; 63-65. Decision based on Non-MTUS Citation FDA Prescribing Information Orphenadrine Citrate (Norflex) <http://www.drugs.com/pro/orphenadrine-extended-release-tablets.html> <http://www.drugs.com/monograph/norflex.html>

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses muscle relaxants. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) states that muscle relaxants seem no more effective than NSAIDs for treating patients with musculoskeletal problems. Muscle relaxants may hinder return to function by reducing the patient's motivation or ability to increase activity. Table 3-1 states that muscle relaxants are not recommended. Chronic Pain Medical Treatment Guidelines (Page 63-66) addresses muscle relaxants. Muscle relaxants should be used with caution as a second-line option for short-term treatment. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. According to a review in American Family Physician, muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Orphenadrine Citrate (Norflex) has been reported in case studies to be abused for euphoria and to have mood elevating effects. FDA Prescribing Information states that Orphenadrine Citrate (Norflex) is indicated for acute musculoskeletal conditions. Orphenadrine has been chronically abused for its euphoric effects. The mood elevating effects may occur at therapeutic doses of Orphenadrine. Medical records document that the patient's occupational injuries are chronic. FDA guidelines state that Orphenadrine (Norflex) is indicated for acute conditions. The use of Orphenadrine for chronic conditions is not indicated. Medical records document the long-term use of muscle relaxants. MTUS and ACOEM guidelines do not recommend the long-term use of muscle relaxants. MTUS and ACOEM guidelines do not recommend the long-term use of muscle relaxants. The medical records and MTUS, ACOEM, and FDA guidelines do not support the use of Orphenadrine Citrate (Norflex). Therefore, the request for Orphenadrine ER 100mg is not medically necessary.