

Case Number:	CM13-0048103		
Date Assigned:	12/27/2013	Date of Injury:	01/24/1991
Decision Date:	04/22/2014	UR Denial Date:	10/23/2013
Priority:	Standard	Application Received:	11/04/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgeon, Sports Medicine and is licensed to practice in California. 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 physician 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 patient is a 55-year-old female who reported an injury on 01/24/1991. The patient is currently diagnosed with lumbosacral spine pain, status post left total knee replacement in 2006, right arm/hand pain and weakness with carpal tunnel syndrome, status post right total knee replacement in 2007 and status post SI neurotomy bilaterally at L5, S1, S2, S3 and S4 in 2011. The patient was seen by [REDACTED] on 06/06/2013. The patient reported ongoing lower back and bilateral lower extremity pain. Physical examination revealed guarding with range of motion testing of the bilateral knees, tenderness to palpation, tenderness at the sacral area from the neurolysis procedure, pain along the paraspinal muscles of the lumbar spine, decreased sensation to light touch at the S1 and L5 dermatomes, a positive Patrick's maneuver, a positive Faber's maneuver, tenderness to palpation over the facet joints bilaterally, spasm and positive stork testing. Treatment recommendations included a revision surgery for severe laxity to the bilateral knees, physical therapy, a trochanteric bursal injection and the continuation of current medications, including Lunesta, alprazolam, DSS sodium, OxyContin, Neurontin, ibuprofen, Savella, Norco, Zanaflex and gabapentin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trochanteric bursal injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-345, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG knee, hip/pelvis; ODG formulary

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis Chapter, Trochanteric bursitis injections.

Decision rationale: The Official Disability Guidelines state that trochanteric bursitis injections are recommended. For trochanteric pain, a corticosteroid injection is safe and highly effective with a single corticosteroid injection often providing satisfactory pain relief. As per the documentation submitted, there was no evidence of localized hip pathology to suggest the need for a bursal injection. The medical necessity has not been established. Additionally, there was no evidence of a recent failure to respond to conservative treatment prior to the request for injection therapy. Based on the clinical information received, the request is non-certified.

Sacroiliac joint injection: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: Official Disability Guidelines (ODG) Hip & Pelvis Chapter, Sacroiliac joint blocks

Bilateral knee revision surgery: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state that referral for surgical consultation may be indicated for patients who have activity limitations for more than 1 month and the failure of exercise programs to increase range of motion and strength of the musculature around the knee. As per the documentation submitted, the patient's physical examination on the requesting date of 06/06/2013 only revealed guarding against range of motion testing and pain to palpation across the anterior joint space and medial and lateral patellar ridges. There was no documentation of significant instability. There was also no evidence of a recent failure to respond to conservative treatment. Based on the clinical information received, the request is non-certified.

Lunesta 3 mg one tablet by mouth nightly as needed, 10 tablets: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG formulary

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment.

Decision rationale: The Official Disability Guidelines state that insomnia treatment is recommended based on etiology. Lunesta has demonstrated reduced sleep latency and sleep maintenance. As per the documentation submitted, the patient has continuously utilized this medication. However, there is no evidence of chronic insomnia or sleep disturbance. It is also unknown as to whether the patient has tried and failed nonpharmacologic treatment prior to the initiation of a prescription product. Based on the clinical information received, the request is non-certified.

Alprazolam 0.5 mg tablets one tablet by mouth nightly as needed, 30 tablets: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 25.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

Decision rationale: The California MTUS Guidelines state that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven, and there is a risk of dependence. A more appropriate treatment for anxiety disorder is an antidepressant. As per the documentation submitted, the patient has continuously utilized this medication. However, there is no evidence of anxiety or depressive symptoms. As the guidelines do not recommend the long-term use of this medication, the current request is not medically appropriate. Therefore, the request is non-certified.

Norco 10/325 mg one tablet by mouth every 6 hours, 120 tablets: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The California MTUS Guidelines state that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessment should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects should occur. The patient has continuously utilized this medication. Despite ongoing use, the patient continues to report high levels of pain. There is no significant change in the patient's physical examination that would

indicate functional improvement. Based on the clinical information received, the request is non-certified.

Zanaflex 4 mg one tablet by mouth daily, 30 tablets: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 67. Decision based on Non-MTUS Citation ODG for muscle relaxants: (ODG-PAIN chapter)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: The California MTUS Guidelines state that muscle relaxants are recommended as non-sedating second-line options for the short-term treatment of acute exacerbations in patients with chronic low back pain. The efficacy appears to diminish over time, and prolonged use may lead to dependence. As per the documentation submitted, the patient has continuously utilized this medication. There was no documentation of palpable muscle spasm or spasticity on physical examination. As the guidelines do not recommend the long-term use of this medication, the current request cannot be determined as medically appropriate. Therefore, the request is non-certified.