

Case Number:	CM13-0062364		
Date Assigned:	04/09/2014	Date of Injury:	08/25/2006
Decision Date:	06/12/2014	UR Denial Date:	12/03/2013
Priority:	Standard	Application Received:	12/06/2013

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 and Rehabilitation, has a subspecialty in Interventional Spine 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 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 patient is a 56 year-old male who was injured on 8/25/06. He has been diagnosed with lumbar sprain; lumbar osteoarthritis; lumbar facet syndrome; lumbar radiculopathy; trochanteric bursitis and hip pain. According to the 10/31/13 pain management/physiatry report by the physician, the patient presents with persistent lower back pain, 7/10 sharp, stabbing pain with a portion radiating to the right hip. The physician states the medications are helping and the patient was requesting refills. He was taking Lyrica, Lisinopril, clonidine, Flexeril, Norco and omeprazole and Sennakot. He is reported to have difficulty sleeping on the right side due to right greater trochanteric bursitis. The physician suggests trochanteric bursa injection. On 12/3/13 UR denied the right trochanteric bursa injection; refills for Norco 10/325mg; and refills of cyclobenzaprine.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT GREATER TROCHANTER BURSAL STEROID INJECTION: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Gluteus Medius Tendinosis/Tears And Trochanteric Bursitis/Pain

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

Decision rationale: The patient presents with lower back pain and symptomatic right greater trochanteric bursitis that interferes with his sleep. I have been asked to review for the trochanteric bursa injection. MTUS chronic pain and ACOEM did not discuss trochanteric bursa injections, so ODG guidelines were consulted. ODG guidelines state: "Corticosteroid injections are effective for greater trochanteric pain syndrome (GTPS) managed in primary care, according to a recent RCT." The request for the right greater trochanteric bursal steroid injections appears to be in accordance with ODG guidelines.

REFILL OF NORCO 10/325 #90 WITH NO REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 88-89.

Decision rationale: According to the 10/31/13 pain management/physiatry report by [REDACTED], the patient presents with persistent lower back pain, 7/10 sharp, stabbing pain with a portion radiating to the right hip. The physician states the medications are helping with pain. UR denied the use of Norco because there was not functional improvement. MTUS criteria for long term use of opioids states to "Document pain and functional improvement and compare to baseline" The physician states Norco helps, but did not compare pain or function to a baseline. The subsequent report dated 2/11/14 from [REDACTED], notes the UR denial, but still does not discuss efficacy of Norco, and states he will just bill through the patient's private insurance. Based on the reporting, it is unknown whether Norco decreases the pain levels a significant amount that would be measurable on a subjective 0-10 VAS scale. There is no discussion of duration of benefit, if any from use of Norco. There is no mention of improved function or improved quality of life with use of the medication. The reporting is not in accordance with MTUS guidelines for continued use of Norco.

REFILL OF CYCLOBENZAPRINE 7.5MG #90 WITH NO 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 Page(s): 63-66.

Decision rationale: According to the 10/31/13 pain management/physiatry report, the patient presents with persistent lower back pain, 7/10 sharp, stabbing pain with a portion radiating to the right hip. The records show the patient had been using Flexeril since at least 9/26/13. MTUS guidelines specifically states that cyclobenzaprine is not recommended for use over 3-weeks.

The request for continued use of cyclobenzaprine on 10/31/13 will exceed the MTUS recommendations.