

Case Number:	CM14-0163097		
Date Assigned:	10/24/2014	Date of Injury:	03/17/2005
Decision Date:	12/11/2014	UR Denial Date:	09/05/2014
Priority:	Standard	Application Received:	10/03/2014

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 Orthopedic Surgery and is licensed to practice in 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 50-year-old female who reported an injury on 03/17/2005. The mechanism of injury involved a fall. The current diagnoses include lumbar degenerative disc disease, hand pain, cervical pain, cervical disc disorder, cervical radiculopathy, mood disorder, foot pain, hip bursitis, and pain in a joint of the lower leg. The injured worker was evaluated on 10/22/2014 with complaints of lower back ache, bilateral hip pain, and bilateral knee pain. Previous conservative treatment is noted to include physical therapy and medications. The current medication regimen includes Lidoderm 5% patch, Hydroxyzine 50mg, Roxicodone 15 mg, Soma 350mg, MS-Contin 30mg, Dexilant 60mg, Cymbalta 60mg, Neurontin 300mg, and Lunesta 3mg. Physical examination revealed an antalgic gait, restricted lumbar range of motion, 20 degree flexion, 5 degree extension, hypertonicity and tenderness in the paravertebral muscles, and a flexion contracture of the 3rd digit of the right hand. Examination of the bilateral hips revealed restricted range of motion and tenderness over the trochanter area. Treatment recommendations included continuation of the current medication regimen and 12 sessions of physical therapy. It is noted that the injured worker received a denial for bilateral trochanteric hip injections. A Request for Authorization form was then submitted on 10/28/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Soma 350mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 29. Decision based on Non-MTUS Citation ACOEM page 47

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

Decision rationale: The California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short term treatment of acute exacerbations. The injured worker has utilized this medication since 10/2013. There is no documentation of objective functional improvement. The California MTUS Guidelines do not recommend long term use of muscle relaxants. There is also no frequency listed in the request. As such, the request is not medically necessary.

MS Contin 30mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80-81.

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

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has continuously utilized this medication since 10/2013. There is no documentation of objective functional improvement. There is also no frequency listed in the request. As such, the request is not medically necessary.

Roxicodone 15mg #180: Upheld

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

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

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The injured worker has continuously utilized this medication since 10/2013. There is no documentation of objective functional improvement. There is also no frequency listed in the request. As such, the request is not medically necessary.

Lidoderm 5% Patch #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56-57.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The California MTUS Guidelines state Lidocaine is indicated for neuropathic pain after there has been evidence of a trial of anticonvulsants and antidepressants. As per the documentation submitted, the injured worker has continuously utilized this medication. There is no documentation of objective functional improvement. There is also no frequency listed in the request. As such, the request is not medically necessary.

Lunesta 3mg #120: Upheld

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

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 recommend insomnia treatment based on etiology. Lunesta has demonstrated reduced sleep latency and sleep maintenance. The injured worker does not maintain a diagnosis of insomnia disorder. The injured worker has utilized this medication since 10/2013. There is no documentation of functional improvement. There is also no frequency listed in the request. As such, the request is not medically appropriate.

Neurontin 300mg #360: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-19.

Decision rationale: The California MTUS Guidelines state Gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia, and has been considered as a first line treatment for neuropathic pain. The injured worker has utilized this medication since 10/2013 without any evidence of objective functional improvement. There is also no frequency listed in the request. As such, the request is not medically necessary.

Hydroxyzine HCL 50mg #540: Upheld

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

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, Anxiety medications in chronic pain

Decision rationale: The Official Disability Guidelines state Hydroxyzine is used to treat anxiety disorder. The injured worker does not maintain a diagnosis of anxiety disorder. The injured worker has continuously utilized this medication since 10/2013. There is no documentation of functional improvement. There is also no frequency listed in the request. As such, the request is not medically necessary.

Bilateral trochanteric hip injections #2: Upheld

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

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 trochanteric bursitis injections are recommended. Gluteus medius tendinosis/tears and trochanteric bursitis pain are symptoms that are often related and commonly corresponded with shoulder tendinosis and subacromial bursitis. For trochanteric pain, corticosteroid injection is safe and highly effective. The injured worker's physical examination does reveal tenderness to palpation. However, the injured worker has been previously treated with bilateral trochanteric hip injections. There is no documentation of objective functional improvement. Therefore, additional treatment cannot be determined as medically necessary at this time.