

Case Number:	CM14-0075868		
Date Assigned:	07/16/2014	Date of Injury:	02/03/2011
Decision Date:	08/14/2014	UR Denial Date:	05/02/2014
Priority:	Standard	Application Received:	05/23/2014

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 Occupational Medicine, and is licensed to practice in Hawaii. 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:

This case is a 58 year old male with a date of injury on 2/3/2011. A review of the medical records indicate that the patient is undergoing treatment for left hip pain and right acetabular labrum tear. Subjective complaints (8/9/2013) include 6/10 pain to right hip that is getting worse. Objective findings (6/28/2013) include tenderness of left hip, decreased range of motion and 4/5 strength of left hip, and negative FABER test. Imaging has included (7/20/2013) lumbar MRI showing spinal canal stenosis of L4-5 and MR arthrogram of right hip. Treatment includes Soma 10mg (since at least 7/2013), Vicodin, hydrocodone-acetaminophen, TENs unit, right hip arthroscopic surgery, right hip steroid injection (at least 2 injections), and Norco (since at least 6/2013).

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI left hip: 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))- Treatment; Integrated Treatment/ Disability Duration Guidelines/ Indications for Imaging.

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

(Acute and Chronic), MRI (magnetic resonance imaging) Other Medical Treatment Guideline or Medical Evidence: ACOEM V.3, Hip and Groin Disorders, Diagnostic Testing, MRI.

Decision rationale: ODG states Recommended as indicated below. MRI is the most accepted form of imaging for finding avascular necrosis of the hip and osteonecrosis. And further outlines the following indications for MRI Osseous, articular or soft-tissue abnormalities, Osteonecrosis, Occult acute and stress fracture, Acute and chronic soft-tissue injuries, Tumors. ACOEM version 3 has three recommendations for MRI of hip: 1) MRI is recommended for select patients with subacute or chronic hip pain with consideration of accompanying soft tissue pathology or other diagnostic concerns. 2) MRI is recommended for diagnosing osteonecrosis. 3) MRI is not recommended for routine evaluation of acute, subacute, or chronic hip joint pathology, including degenerative joint disease. Medical documents do not indicate concerns for avascular necrosis, osteonecrosis, stress fracture, or soft-tissue abnormalities of the left hips. The treating physician does not document any conditions or concerns that meet ODG or ACOEM guidelines. As such, the request for MRI left hip is not medically necessary.

Bilateral hip Epidural Steroid Injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection (ESIS).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hips and Pelvis (Acute and Chronic), Intra-articular steroid hip injection (IASHI).

Decision rationale: ODG refers to Intra-articular steroid hip injection for steroid injection. ODG states Not recommended in early hip osteoarthritis (OA). Under study for moderately advanced or severe hip OA, but if used, should be in conjunction with fluoroscopic guidance. Recommended as an option for short-term pain relief in hip trochanteric bursitis. Medical records do not indicate that the patient has bilateral moderately advanced or severe OA or bilateral hip trochanteric bursitis. As such, the request for Bilateral hip Epidural Steroid Injection is not medically necessary.

Norco 10mg/325mg tablets QTY 240.00: 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): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Opioids.

Decision rationale: ODG does not recommend the use of opioids except for short use for severe cases, not to exceed 2 weeks. The patient has exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that ongoing review and documentation of pain relief, functional status, appropriate medication

use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life, which is necessary to continue opioid usage past the recommended 2 week period. As such, the question for Norco 325/10mg # 120 is not medically necessary.

Soma 350mg tablets QTY: 90.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) and Muscle relaxants (for pain) Page(s): 29, 63-66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Soma (Carisoprodol).

Decision rationale: MTUS states Not recommended. This medication is not indicated for long-term use. Carisoprodol is a commonly prescribed, centrally acting skeletal muscle relaxant whose primary active metabolite is meprobamate (a schedule-IV controlled substance). Carisoprodol is now scheduled in several states but not on a federal level. It has been suggested that the main effect is due to generalized sedation and treatment of anxiety. Abuse has been noted for sedative and relaxant effects. In regular abusers the main concern is the accumulation of meprobamate. Carisoprodol abuse has also been noted in order to augment or alter effects of other drugs. ODG States that Soma is Not recommended. This medication is FDA-approved for symptomatic relief of discomfort associated with acute pain in musculoskeletal conditions as an adjunct to rest and physical therapy (AHFS, 2008). This medication is not indicated for long-term use. The patient has been on the medication since 7/2013. The request for SOMA 350MG, #90 is in excess of the guidelines. As such, the request for SOMA 350MG, #90 is not medically necessary.