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| Case Number: | CM14-0145942 | | |
| Date Assigned: | 09/12/2014 | Date of Injury: | 04/24/2000 |
| Decision Date: | 10/14/2014 | UR Denial Date: | 08/28/2014 |
| Priority: | Standard | Application Received: | 09/08/2014 |

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 Physical Medicine and Rehabilitation 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:

Patient is a 46-year-old female who has submitted a claim for left shoulder rotator cuff tear status post repair, bilateral occipital tension headache, migraine headache with aura, myofascial pain syndrome, low back pain, bilateral sacroiliac enthesopathy, bilateral trochanteric bursitis, right piriformis syndrome with right sciatic neuritis, right leg radiating pain, depression, sleep disturbance secondary to chronic pain, and bilateral subacromial and bilateral subdeltoid bursitis associated with an industrial injury date of 4/24/2000. Medical records from 2014 were reviewed. Patient complained of left sided low back pain, left knee pain, and bilateral hip pain, rated 7/10 in severity. Patient was directed to increase intake of oxycodone due to inadequate pain control. There was a mild decrease in the episodic pain afterwards. Constipation was a noted side effect from opioid use. Physical examination showed a marked right iliolumbar and right sacroiliac ligament tenderness, healed left shoulder incision, and unchanged right trochanteric bursa and right subacromial bursa tenderness. Shoulder range of motion at the right was restricted on all planes. There was right sacroiliac joint hypomobility. Treatment to date has included left shoulder arthroscopic decompression in 2004, left shoulder rotator cuff repair in 2009, left shoulder arthroscopy in 2011 and 2012, L5 to S1 anterior and posterior interbody fusion, bilateral subacromial and bilateral subdeltoid bursa injections, bilateral trochanteric bursitis and left iliolumbar injection (resulting to 70% pain relief), physical therapy, lumbar epidural steroid injection, and medications such as OxyContin, oxycodone, ibuprofen, and Soma (all since March 2014). Utilization review from 8/28/2014 denied the requests for Oxycontin 40mg #90, Oxycodone 15mg #90, and Ibuprofen 800mg #60 because of lack of objective functional improvement with medication use; denied Soma 350mg #20 because of no evidence of muscle spasm; denied Senna/Docusate #240 because the requests for opioids were likewise not certified; and modified the request for Bilateral Iliolumbar Ligament and Bilateral

Trochanteric Bursa Steroid Injections Under Fluoro Guidance times two into one only because of evidence of relief from previous injection, however, ligamentous injections were not supported by the guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin 40mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26, Opioids Page(s): 78.

Decision rationale: As stated on page 78 of California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, patient has been on Oxycontin since March 2014. However, the medical records do not clearly reflect continued analgesia and continued functional benefit. Urine drug screen result was likewise not submitted for review. California (MTUS) Guidelines require clear and concise documentation for ongoing management. Therefore, the request for Oxycontin 40mg, #90 is not medically necessary.

Oxycodone 15mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Chronic Pain Page(s): Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26, Opioids Page(s): 78.

Decision rationale: As stated on page 78 of California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, patient has been on Oxycodone since March 2014. However, the medical records do not clearly reflect continued analgesia and continued functional benefit. Urine drug screen result was likewise not submitted for review. California (MTUS) Guidelines require clear and concise documentation for ongoing management. Therefore, the request for Oxycodone 15mg, #90 is not medically necessary.

Ibuprofen 800mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2, NSAIDs Page(s): 46.

Decision rationale: As stated on page 46 of the California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment guidelines, non-steroidal anti-inflammatory drugs (NSAIDs) are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and that there is no evidence of long-term effectiveness for pain or function. In this case, patient has been on ibuprofen since March 2014. However, there is no documentation concerning pain relief and functional improvement derived from its use. Long-term use is likewise not recommended. Therefore, the request for ibuprofen 800mg, #60 is not medically necessary

Soma 350mg #20: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Procedure Summary

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26, Carisoprodol (Soma) Page(s): 29.

Decision rationale: As stated on page 29 of California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines, carisoprodol (Soma) is a centrally acting skeletal muscle relaxant that is not indicated for long-term use. Carisoprodol abuse has been noted in order to augment or alter effects of other drugs such as hydrocodone, tramadol, benzodiazepine and codeine. In this case, patient has been on carisoprodol since March 2014. However, there is no documentation concerning pain relief and functional improvement derived from its use. Furthermore, this medication is being requested together with opioids, which is not recommended by the guidelines due to high potential of abuse. Long-term use of Soma is likewise not recommended. The most recent physical examination also failed to show evidence of muscle spasm. Therefore, the request for Soma 350mg, #20 is not medically necessary.

Senna/Docusate #240: 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), Low Back

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26, Opioids, Initiating Therapy Page(s): 77.

Decision rationale: Page 77 of California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines states that with opioid therapy, prophylactic treatment of constipation should be initiated. Docusate is a stool softener. In this case, patient is on opioid therapy since March 2014. Patient reported constipation from opioid use; hence, treatment with a stool softener has been established. However, simultaneous requests for Oxycodone and Oxycontin have been deemed not medically necessary. There is no clear indication for certifying a stool softener at this time. Therefore, the request for Senna / Docusate #240 is not medically necessary.

Bilateral Iliolumbar Ligament and Bilateral Trochanteric Bursa Steroid Injections Under Fluora Guidance x2: 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), Hip & Pelvis

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis, Intra-articular steroid hip injection (IASHI); Low Back Section, Ligamentous Injection

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) does not address the topic on piriformis injections. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and Official Disability Guidelines (ODG) was used instead. ODG states that intra-articular steroid hip injection (IASHI) is not recommended in early hip osteoarthritis (OA). It is under study for moderately advanced or severe hip OA. IASHI is recommended as an option for short-term pain relief in hip trochanteric bursitis. Intraarticular glucocorticoid injection with or without elimination of weight-bearing does not reduce the need for total hip arthroplasty in patients with rapidly destructive hip osteoarthritis. IASHI should be used in conjunction with fluoroscopic guidance since the hip joint is one of the most difficult joints in the body to inject accurately and entry of the therapeutic agent into the synovial space cannot be ensured without fluoroscopic guidance. ODG also states that ligamentous injections involve the injection of sclerosing agents into interspinous ligaments in the low back. One major evidence based guideline has concluded that trigger point and ligamentous injections are likely to be beneficial for chronic low back pain. In this case, patient complained of chronic bilateral hip pain (lateral aspect), rated 7/10 in severity. Physical examination showed a marked right iliolumbar and right sacroiliac ligament tenderness, and unchanged right trochanteric bursa tenderness. There was right sacroiliac joint hypomobility. Diagnoses include bilateral sacroiliac enthesopathy, bilateral trochanteric bursitis, and right piriformis syndrome with right sciatic neuritis. Previous bilateral trochanteric bursitis and left iliolumbar injection resulted to 70% pain relief; hence this request for re-injection. The medical necessity for a repeat procedure has been established. Guideline criteria were met. Therefore, the request for Bilateral Iliolumbar Ligament and Bilateral Trochanteric Bursa Steroid Injections under Fluoro Guidance times two is medically necessary.