

Case Number:	CM14-0002125		
Date Assigned:	01/24/2014	Date of Injury:	08/15/1994
Decision Date:	06/13/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/07/2014

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, 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 50-year-old male with a date of injury of 08/15/1994. The listed diagnoses per [REDACTED] are: Right lumbar facet joint pain, 1. L4-L5 and L5-S1, 2. Status post fluoroscopy-guided right L4-L5 and right L5-S1 facet joint radiofrequency, 3. Lumbar disk protrusion. 4. Central disk protrusion at L4-L5 and L5-S1, 5. Bilateral lumbar facet joint arthropathy, 6. Mild to moderate ligamentum flavum hypertrophy at L2 to S1.7. Lumbar strain/sprain.8. Lumbar degenerative disk disease, 9. Right peroneal neuropathy with right foot drop. According to the 06/25/2013 progress report by [REDACTED], the patient presents with right low back pain. The pain is a 4/10 to 5/10. The patient had an epidural steroid injection in September 2012, and the treater requested a repeat injection which has not been authorized. On 12/19/2013, the patient presented for a follow-up for his right low back pain. He reported constant, dull, ache, and intermittent sharp pain. He also complains of peroneal pain. There is decreased range of motion in all planes and painful lumbar flexion. Treatment plan includes "Lodine 400 mg 1 tablet p.o. t.i.d. #90 with 5 refills and Medrol Dosepak to be used as directed #1 with 0 refills to treat the patient's aggravated right peroneal pain." Utilization review denied the request on 12/30/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

LODINE 400MG # 90 WITH 5 REFILLS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Inflammatory Medications Page(s): 60-61,22.

Decision rationale: This patient presents with chronic low back pain. The treater is requesting Lodine 400 mg #90 with 5 refills. For anti-inflammatory medication, the Chronic Pain Medical Treatment Guidelines page 22 states anti-inflammatory are the traditional line of treatment to reduce pain so activity of functional restoration can resume, but long term use may not be warranted. Chronic Pain Medical Treatment Guidelines further states on page 60 that for medications for chronic pain, pain assessment, and functional level should be documented as related to medication use. In this case, the treater provides two progress reports for review, 06/25/2013 and 12/19/2013. Both reports do not discuss efficacy with Lodine. Without documentation of pain and function, continued use of medication is not recommended. Therefore the request is not medically necessary.

MEDROL DOSE PACK #1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

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: This patient presents with chronic low back pain. The treater is requesting Medrol Dosepak #1 to treat the patient's aggravated right peroneal pain. MTUS guidelines do not discuss use of Medrol pack. However, ODG guidelines recommends "oral corticosteroids for limited circumstances as noted below for acute radicular pain, not recommended for acute non radicular pain (i.e., axial pain) or chronic pain. Multiple severe adverse effects have been associated with systemic steroid use. This is more likely to occur after long-term use." This patient has chronic peroneal pain that was recently aggravated. ODG does not recommend oral corticosteroids for non-radicular or chronic pain. Therefore the request is not medically necessary.