

Case Number:	CM14-0151058		
Date Assigned:	09/19/2014	Date of Injury:	02/25/2010
Decision Date:	10/21/2014	UR Denial Date:	08/27/2014
Priority:	Standard	Application Received:	09/16/2014

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 Internal Medicine and is licensed to practice in California and Illinois. 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 48-year-old male smoker who reported an injury of unspecified mechanism on 02/25/2010. On 07/02/2014, his complaints included increasing back pain radiating down both legs. He was tender to palpation in the paralumbar area. Active voluntary range of motion of the thoracolumbar spine was severely limited. The patient could only forward flex to approximately 20 degrees and extend to 5 to 10 degrees before stopping to complain of back pain. Lateral bending was approximately 5 degrees. Straight leg raising test was positive bilaterally at 50 degrees in both the lying and sitting position. X-ray studies revealed advanced disc disease from L3 to the sacrum and retrolisthesis at L3-4 and L4-5. Radiculopathy appeared to be arising from the severe stenosis at L5-S1 as documented in an MRI of 06/27/2011. The recommendation was for an epidural steroid injection. It went on to state that if all conservative treatment failed, a surgical intervention may be necessary. No medications were mentioned in this progress note. There was no rationale or Request for Authorization included in this worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective - Deltasone Dosepak 5mg #21 Qty1, as directed, dispensed 7/2/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain Chapter, Oral Corticosteroids Official Disability Guidelines Lumbar Chapter

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

Decision rationale: Per the California ACOEM guidelines, oral corticosteroids are not recommended for the treatment of low back disorders. The guidelines do not support this intervention. Therefore, this request for Retrospective - Deltasone Dosepak 5mg #21 Qty1, as directed, dispensed 7/2/2014 is not medically necessary.

Restrospective - Vicoprofen 200mg/7.5mg #60 Qty 2, 1 every 4-6 hours prn pain, dispensed 7/2/2014: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Ibuprofen (Vicoprofen; generic available) ; Opioids cr.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS
Page(s): 74-95.

Decision rationale: The California MTUS Guidelines recommend ongoing review of opioid use, including documentation of pain relief, functional status, appropriate medication use, and side effects. It should include current pain and intensity of pain before and after taking the opioid. Satisfactory response to treatment may be indicated by decreased pain, increased level of function, or improved quality of life. In most cases, analgesic treatment should begin with acetaminophen, aspirin, NSAIDs, antidepressants, and/or anticonvulsants. There was no documentation in the submitted chart regarding appropriate long term monitoring/evaluation, including side effects, failed trials of NSAIDs, aspirin, antidepressants or anticonvulsants, quantified efficacy, or drug screens. The clinical information submitted failed to meet the evidence based guidelines for continued use of opioids. Therefore, this request for Restrospective - Vicoprofen 200mg/7.5mg #60 Qty 2, 1 every 4-6 hours prn pain, dispensed 7/2/2014 is not medically necessary.