

Case Number:	CM14-0032922		
Date Assigned:	03/21/2014	Date of Injury:	05/12/1991
Decision Date:	04/25/2014	UR Denial Date:	02/24/2014
Priority:	Standard	Application Received:	03/15/2014

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 Family Medicine 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 56-year-old female who reported an injury on 05/12/1991. The mechanism of injury was not stated. The patient is diagnosed as status post fluoroscopically guided right sacroiliac joint radiofrequency nerve ablation, status post positive fluoroscopically guided diagnostic right sacroiliac joint injection, right sacroiliac joint pain, status post percutaneous permanent spinal cord stimulator implant, failed back surgery syndrome, lumbar radiculopathy, postsurgical changes following L4-5 fusion, multilevel lumbar disc protrusion, lumbar degenerative disc disease, lumbar facet joint arthropathy, diabetes mellitus, and hypertension. The patient was seen by [REDACTED] on 03/11/2014. The patient reported bilateral lower back pain with radiation to the right lower extremity. Physical examination revealed a well-healed scar at the site of the spinal cord stimulator incision, restricted lumbar range of motion, positive provocative maneuvers of the right sacroiliac joint, 4/5 strength in the right lower extremity, intact sensation with the exception of the L4 and L5 dermatomes of the right lower extremity, and an antalgic gait. Treatment recommendations included an appeal request for a Medrol Dosepak.

IMR ISSUES, DECISIONS AND RATIONALES

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

THE REQUEST FOR A MEDROL DOSE PACK: 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, Oral Corticosteroid Section.

Decision rationale: The Official Disability Guidelines (ODG) state oral corticosteroids are not recommended for chronic pain. There is no data on the efficacy and safety of systemic corticosteroids in chronic pain, and given their serious adverse effects, they should be avoided. It was noted that the patient's Medrol Dosepak was medically necessary to treat an acute exacerbation of bilateral lower back pain with left lower extremity radicular pain. However, Official Disability Guidelines do not recommend oral corticosteroids for chronic pain. Therefore, the request cannot be determined as medically appropriate. As such, the request is non-certified.