

Case Number:	CM14-0060579		
Date Assigned:	07/09/2014	Date of Injury:	05/03/2006
Decision Date:	08/20/2014	UR Denial Date:	04/18/2014
Priority:	Standard	Application Received:	05/01/2014

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 Emergency 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:

Patient has a reported date of injury on 5/3/2006. No mechanism of injury was provided. Patient has a history of total disc arthroplasty at L5-S1 in 2007, right L5-S1 laminectomy in 2009, right lower extremity radiculopathy and right leg chronic pain syndrome. Most recent medical records submitted are from 4/8/14. Patient has complaints of back pain radiating to right buttock, down posterior thigh into the foot. Pain is reported as 7/10. Pain worsened after CT myelogram on 2/17/14. Objective exam reveals normal gait, tenderness over lumbar paravertebral muscles, and decreased sensation over L5 dermatome distribution. Range of motion is decreased, especially extension. Pain is noted over greater trochanter. 4/8/14 report from primary treating physician states that patient was given Medrol dose pack and received a right greater trochanteric injection. CT myelogram reveals post-surgical changes, L3-4, L4-5 with mild disc bulges and diffuse degenerative changes. No other significant anomalies were noted. Records state patient is currently on Flexeril, Norco, Colace, Cymbalta, Trazodone, Wellbutrin and Clonazepam. Urine Drug Screen on 2/7/14 was positive for hydrocodone/norhydrocone, 7-aminoclonazepam and acetaminophen. Patient is reportedly undergoing pool/aqua therapy. Independent Medical Review is for Medrol dose pack, Norco 10/325 and retrospective cortisone injection to right greater trochanter. Prior UR on 4/18/14 recommended non certification.

IMR ISSUES, DECISIONS AND RATIONALES

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

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, Pain Chapter, Oral Corticosteroids.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Complaints - Thoracic or Lumbar, Corticosteroids.

Decision rationale: MTUS Chronic Pain and ACOEM Guidelines do not adequately address this issue. As per Official Disability Guidelines (ODG), corticosteroids may be used under certain criteria. 1) Patient should have clear-cut signs of radiculopathy. Patient meets criteria. 2) Risks of steroid use should be discussed and documented. Documentation does not meet criteria. 3) Minimal benefit of steroids should be discussed and documented. Documentation does not meet criteria. 4) Use during acute phase. Patient meets criteria. Documentation provided does not support the request for Medrol dose pack. Medrol dose pack is not medically necessary.

Norco 10/325mg: 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): 76-78.

Decision rationale: Norco is an opioid combination of acetaminophen and hydrocodone. As per MTUS Chronic Pain Guidelines, there must be appropriate documentation of analgesia, activities of daily living, adverse events and aberrant behavior. Documentation provided does not meet these criteria. The prescription also does not specify a quantity. Due to incomplete prescription information and not meeting criteria, Norco is not medically necessary.

Retrospective Cortisone Injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Hip and Pelvis Chapter regarding Intra-articular steroid hip injection.

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, Trochanteric Bursitis Injection.

Decision rationale: MTUS Chronic Pain or ACOEM Guidelines do not adequately address this issue. As per Official Disability Guidelines (ODG), Trochanteric Bursitis Injections may be recommended for a diagnosis of Trochanteric Bursitis. Documentation submitted does not demonstrate patient reports of hip/trochanteric pain at the time of injection. There is no proper physical exam documented. Trochanteric cortisone injection in a patient without any

documented history or physical exam to support diagnosis of trochanteric bursitis is not medically necessary.