

<b>Case Number:</b>	CM15-0007236		
<b>Date Assigned:</b>	01/22/2015	<b>Date of Injury:</b>	03/30/2009
<b>Decision Date:</b>	03/24/2015	<b>UR Denial Date:</b>	01/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, Arizona  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 55-year-old female who reported injury on 03/30/2009. The mechanism of injury occurred when her apron got caught on a hook and pulled her backwards. Diagnoses include acute low back pain, lumbar radiculopathy, lumbar degenerative disc disease, right knee medial compartment degenerative joint disease, status post right knee arthroscopy. Past treatments included injections, surgery, medications. On 12/11/2014, the injured worker complained of constant moderate right knee pain causing swelling, clicking, locking, tingling, popping, grinding, weakness, numbness, and tenderness rated at 5/10 to 10/10. The physical examination of the right knee revealed range of motion with extension at 15 degrees and flexion at 110 degrees. The injured worker also had a trace test of the patellofemoral compression and crepitation test. The injured worker's motor exam and sensation were indicated to be intact bilaterally. The physical examination of the lumbar spine revealed muscle spasms were demonstrated over the paraspinal muscles on the right low back. Lumbar spine range of motion was indicated for flexion at 70 degrees, extension at 20 degrees, right lateral bending at 15 degrees, left lateral bending at 10 degrees, negative straight leg raise on the right and positive on the left. The injured worker also had a positive left fabere and positive dorsiflexion on the right. The injured worker's deep tendon reflexes, sensation and motor exam were indicated to be intact and within normal limits. Her relevant medications include meloxicam and tramadol. The treatment plan included Ultracet, discontinue NSAIDs due to hypertension, recommendation of Decadron series, and an injection to the right knee. A rationale was not provided for Decadron. A Request for Authorization form was submitted on 12/24/2014.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Decadron IM Series QTY: 3:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back, Corticosteroids (oral/parenteral/IM for low back pain)

**Decision rationale:** The request for Decadron IM series QTY: 3 is not medically necessary. According to the California MTUS /ACOEM Guidelines, invasive techniques such as local injections such as facet joint injections of cortisone and lidocaine are of questionable merit. More specifically, the Official Disability Guidelines state that corticosteroid is an intramuscular injection for the low back may be recommended in limited circumstances and is noted for acute radicular pain; and that research has provided limited evidence of efficacy with this medication. In addition, guidelines state that it is not recommended for acute nonradicular pain or chronic pain. The criteria for the use of corticosteroids for the low back include: Patients should have clear cut signs and symptoms of radiculopathy, risk of steroids should be discussed with the patient and documented, patients should be made aware of evidence that research provides evidence of limited efficacy, current research indicates further treatment is most successful; treatment in the chronic phase of injury should generally be after a symptom free period with subsequent exacerbation when there is evidence of no injury. The injured worker was indicated to have a positive straight leg raise on the left. However, there was a lack of documentation showing significant neurological deficits such as decreased motor strength or sensation in a specific dermatomal or myotomal distribution to correlate the findings of radiculopathy. In the absence of clear cut signs and symptoms of radiculopathy upon physical examination and lack of evidence of research indicating efficacy with this medication, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.