

Case Number:	CM15-0036392		
Date Assigned:	03/04/2015	Date of Injury:	12/11/1997
Decision Date:	04/20/2015	UR Denial Date:	01/25/2015
Priority:	Standard	Application Received:	02/25/2015

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: Arizona, Texas
 Certification(s)/Specialty: Internal Medicine

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 57 year old male, who sustained an industrial injury on 12/11/1997. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. Diagnoses include post laminectomy syndrome of the lumbar region, pain in the joint of the ankle and foot, pain in soft tissues of the limb, pain in joint of the upper arm, lumbago, degenerative lumbar/lumbosacral intervertebral disc, intervertebral lumbar disc disorder with myelopathy to the lumbar region, and thoracic lumbosacral neuritis and radiculitis unspecified. Treatment to date has included medication regimen, home exercise program, and use of moist heat. In a progress note dated 01/19/2015 the treating provider reports complaints of increased right leg sciatic, right rib, and right hip pain with a pain rating of a ten out of ten without medication and a three out of ten with medication. The treating physician requested the prescription for Medrol (Pak), but the documentation provided did not indicate the reason for this requested medication. On 01/26/2015 Utilization Review non-certified the requested treatment of Medrol (Pak) 4mg between the dates of 01/19/2015 and 03/23/2015, noting the California Chronic Pain Medical Treatment Guidelines (May 2009) and Official Disability Guidelines: Pain (Chronic) and Low Back-Lumbar & Thoracic (Acute & Chronic).

IMR ISSUES, DECISIONS AND RATIONALES

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

Medrol (pak) 4mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines oral corticosteroids. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-Pain.

Decision rationale: ODG recommends oral corticosteroids for the treatment of acute radicular pain associated with the low back, but not for chronic pain, unless the patient presents with polymyalgia rheumatica. Medrol is not approved for the treatment of pain. In this case, the patient is documented as having an exacerbation of chronic pain. There is no diagnosis of polymyalgia rheumatica or acute radicular pain.