

Case Number:	CM13-0002509		
Date Assigned:	12/27/2013	Date of Injury:	02/21/2010
Decision Date:	02/20/2014	UR Denial Date:	07/09/2013
Priority:	Standard	Application Received:	07/22/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation, and is licensed to practice in California, Maryland, Florida, and the District of Columbia. 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 physician 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:

This is a 70 year old female housekeeper, who sustained an industrial injury on 02/21/10. Patient underwent 2 level lumbar fusion at L4- S1. After surgery patient complaint of weakness in the left lower extremity on 10/15/2012. A CT scan of the back did not show any problems with the hardware. During an office visit on 6/24/13, patient complained of sharp pain in the lower back. Patient indicated the pain was worse than before surgery and rated the pain to range from 2/10 to 7/10.

IMR ISSUES, DECISIONS AND RATIONALES

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

Toradol 60mg IM: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines NSAIDs Page(s): 72,181.

Decision rationale: CA-MTUS (Effective July 18, 2009) page 72 section on Ketorolac [Boxed Warning]:) stipulates that Ketorolac (Toradol[®], generic available): 10 mg. [Boxed Warning]: "This medication is not indicated for minor or chronic painful conditions The oral form is only

recommended for short-term (up to 5 days) in management of moderately severe acute pain that requires analgesia at the opioid level and only as continuation following N or IM dosing, if necessary. This medication is not indicated for minor or chronic painful conditions. Increasing doses beyond a daily maximum dose of 40 mg will not provide better efficacy, and will increase the risk of serious side effects. Dosing: Acute pain (transition from Nor IM) for adults < 65 years of age: 20mg PO followed by 10mg PO every 4 to 6 hours (max 40 mg/day). An oral formulation should not be given as an initial dose. (Toradol Package insert) The FDA has approved a nasal formulation of ketorolac (Sprix) for short-term pain management.

Lumbar x-ray: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: According to CA-MTUS (Effective July 18, 2009) (ACOEM) page 303, under Special Studies and Diagnostic and Treatment Considerations: Lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management. Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began. Techniques vary in their abilities to define abnormalities (Table 12.7). Imaging studies should be reserved for cases in which surgery is considered or red flag diagnoses are being evaluated. Because the overall false positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great.