

Case Number:	CM14-0118884		
Date Assigned:	08/06/2014	Date of Injury:	07/01/2008
Decision Date:	09/17/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	07/28/2014

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 Physical Medicine & Rehabilitation/Pain Medicine and is licensed to practice in Texas & Ohio. 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 injured worker is a 57-year-old male with a reported date of injury on 07/01/2008. The mechanism of injury was not submitted within the medical records. His diagnoses were noted to include: Left shoulder impingement without rotator cuff tear, cervical discopathy, lumbar discopathy, right knee internal derangement with meniscal tear, and status post right knee arthroscopy. His previous treatments were noted to include: Surgery, physical therapy and medications. The progress note dated 06/13/2014 revealed the injured worker complained of neck pain rated at 6/10 to 7/10 and aching in the left shoulder, the worker also complained of stabbing pain in the lower back rated at 4/10. The physical examination of the cervical spine revealed mild tenderness bilaterally in the trapezii and tenderness at the occipital insertion of the paracervical musculature. The range of motion was noted to be flexion was to 30 degrees, extension was to 20 degrees, right/left rotation was to 20 degrees and scapular retraction was limited and produced rhomboid pain. The physical examination of the lumbar spine revealed tenderness from the thoracolumbar spine down to the base of the pelvis. The paralumbar musculature was slightly tight bilaterally and the buttocks were tender. The claimant had some tenderness on stress of the pelvis which indicated micro sacroiliac joint symptomology. The range of motion of the lumbar spine was noted to be flexion was to 20 degrees, extension was to 15 degrees and tilt to the right/left was to 15 degrees. There was no gross motor weakness in the lower extremities, although there was a grade 4+ motor power of the quadriceps, hamstrings and testing caused mild pain. The provider indicated the claimant was given an intramuscular injection of Toradol for acute pain relief. The Request for Authorization form was not submitted within the medical records. The request was for a retrospective intramuscular Toradol 2 cc for acute pain and chiropractic therapy times 8 for cervical and times 8 for the lumbar spine; however, the provider's rationale was not submitted within the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective IM Toradol 2cc: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 72.

Decision rationale: The retrospective intramuscular Toradol 2 cc request is not medical necessary. The injured worker received a previous intramuscular Toradol injection for pain. The California Chronic Pain Medical Treatment Guidelines recommend Toradol for acute pain and state that it is not indicated for minor or chronic painful conditions. The worker's injury is not an acute onset and therefore Toradol is not recommended. Therefore this request is not medically necessary.

Chiropractic Therapy x8 for Cervical Spine, x8 for Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Functional Improvement Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58.

Decision rationale: The request for chiropractic therapy times 8 for cervical, times 8 for lumbar spine is not medically necessary. The injured worker has received previous physical therapy for his right knee. The California Chronic Pain Medical Treatment Guidelines recommend manual therapy for chronic pain if caused by musculoskeletal conditions. Manual therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of manual medicine is the achievement of positive symptomatic or objective measureable gains in functional improvement that facilitate progression in the injured worker's therapeutic exercise program and return to productive activities. The guideline's recommendation for the low back is a trial of 6 visits over 2 weeks, and with evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks. The injured worker has measureable objective functional deficits with regards to range of motion and motor strength; however, the guidelines recommend a trial of 6 visits over 2 weeks and the request exceeds guideline recommendations. Therefore, this request is not medically necessary.