

Case Number:	CM14-0023569		
Date Assigned:	05/12/2014	Date of Injury:	08/07/2008
Decision Date:	07/24/2014	UR Denial Date:	02/17/2014
Priority:	Standard	Application Received:	02/24/2014

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 Anesthesiologist, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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:

This is a 59-year-old male patient with a 8/7/08 date of injury. 3/5/14 progress report indicates left wrist and low back pain, with results to left shoulder pain. Left wrist x-rays demonstrate a partially healed scaphoid fracture. X-rays of the lumbar spine demonstrate L4-S1 AP fusion with hardware. 1/7/14 progress report indicates persistent low back and left wrist pain. 12/20/13 progress report indicates chronic low back pain with radicular symptoms, postlaminectomy syndrome, depression and hypertension. The patient rated his pain at 10/10 bands reported difficulties with activities of daily living. Physical exam demonstrates decreased lumbar range of motion, muscle spasm, positive straight leg raise test on the right. There is atrophy in the right calf. 12/9/13 psychological consultation indicates major depression, recurrent, severe. Correlation with pain complaints was suggested. Treatment to date has included lumbar surgery, TENS, HELP program, and lumbar ESI, acupuncture, Percocet, and activity modification. There is documentation of a previous 2/17/14 adverse determination because Toradol is not indicated in the management of chronic pain conditions.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR ONE (1) TORADOL INJECTION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Toradol Page(s): 72. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Toradol.

Decision rationale: CA MTUS states that Toradol is not indicated for minor or chronic painful conditions. The FDA states that Ketorolac is indicated for the short-term (up to 5 days in adults), management of moderately severe acute pain that requires analgesia at the opioid level and only as continuation treatment following IV or IM dosing of Ketorolac tromethamine. ODG states that Ketorolac, when administered intramuscularly, may be used as an alternative to opioid therapy. However, the patient suffers from chronic pain complaints. There is no evidence that the patient could not be managed on lower levels of care, especially given suggested psychiatric overlay per 12/19/13 consultation. There is no specific indication as to why oral medication would be insufficient. Therefore, the request for RETROSPECTIVE REQUEST FOR ONE (1) TORADOL INJECTION was not medically necessary.