

Case Number:	CM14-0191976		
Date Assigned:	11/25/2014	Date of Injury:	08/31/2010
Decision Date:	01/13/2015	UR Denial Date:	10/17/2014
Priority:	Standard	Application Received:	11/17/2014

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 and Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in California. 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 patient is a 41 year old female with date of injury 8/31/10. The treating physician report dated 10/14/14 (117) indicates that the patient presents with pain affecting the upper back. The patient notes an acute right upper back pain flare-up with intense pain and pulling sensation. The physical examination findings reveal tenderness on palpation of thoracic spine, cervical spine, deltoid muscles, and inferior scapular muscles. Further examination revealed cervical pain with movement, bilateral shoulder pain with movement, decreased sensation in 1, UE, and decreased grip strength in the left hand. Prior treatment history includes prescribed medications, psychiatric care, TENS unit, consult with Ortho surgeon, HEP, chiropractic care, and Ice/heat therapy. Current medications include Naproxen, Omeprazole, Menthoderm gel and Venlafaxine. Treating physician notes that the patient is acutely suicidal. MRI findings reveal a loss of cervical lordotic curvature with no evidence of disk bulge or herniation. The current diagnoses are: 1. Cervical sprain/strain; Neck2. Pain in joint, upper arm3. Thoracic sprain/strain4. Myofascial pain5. Bilateral cervical radiculitis The utilization review report dated 10/17/14 denied the request for Retrospective 1 Toradol 60mg (dos 10/14/2014) based on the requests not satisfying MTUS guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective 1 Toradol 60mg injection for DOS 10/14/2014: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ketorolac (Toradol). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Ketorolac (Toradol)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

Decision rationale: The patient presents with chronic pain affecting the upper back. The current request is for a Retrospective 1 Toradol 60mg injection for DOS 10/14/2014. The treating physician report dated 10/14/14 noted that the patient received a Toradol intramuscular injection for an acute right upper back pain flare-up. MTUS states on pg.72, Ketorolac "This medication is not indicated for minor or chronic painful conditions." Academic Emergency Medicine, Vol. 5, 118-122, Intramuscular ketorolac vs. oral Ibuprofen in emergency department patients with acute pain, study demonstrated that there is "no difference between the two and both provided comparable levels of analgesia in emergency patients presenting with moderate to severe pain." In this case the patient presents with acute flare up with moderate pain affecting the right upper back that was unresponsive to medications, creams and neck support. MTUS supports Toradol injections for acute moderate flare-ups. Recommendation is medically necessary.

Retrospective 60 Fenoprofen 400mg for DOS 10/14/2014: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Fenoprofen (Nalfon).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-73.

Decision rationale: The patient presents with chronic pain affecting the upper back. The current request is for Retrospective 60 Fenoprofen 400mg for DOS 10/14/2014. Fenoprofen is an oral NSAID that is used for the treatment of arthritic pain. The MTUS guidelines support the usage of NSAIDs for the treatment of osteoarthritis and mild to moderate pain. The treating physician report dated 10/14/14 diagnosed the patient with pain in the joint of the upper arm. The report also notes that the request for Fenoprofen was for anti-inflammatory and pain control because the patient was to stop taking Naproxen. The decision to stop prescribing Naproxen was not discussed further. In this case the patient has exhibited symptoms of arthritic pain in the joint of the upper arm and the physician feels that the patient requires NSAID usage; therefore the request for Fenoprofen is within the MTUS guidelines. Recommendation is medically necessary.