

<b>Case Number:</b>	CM14-0198151		
<b>Date Assigned:</b>	12/08/2014	<b>Date of Injury:</b>	01/17/2006
<b>Decision Date:</b>	01/22/2015	<b>UR Denial Date:</b>	11/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/25/2014

### 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 Family Practice 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:

This injured worker is a 66 year old male patient who sustained a work related injury on 1/17/2006. The exact mechanism of injury was not specified in the records provided. The current diagnoses include s/p L3-L5 decompression and fusion and strain of the lumbar and cervical spine. Per the doctor's note dated 11/5/14, the patient has complaints of pain at 8-9/10 without medications and 5/10 with medication. A physical examination of the cervical and lumbar revealed antalgic gait, tenderness on palpation, limited range of motion, Femoral stretch negative bilaterally and Straight-leg raise and bowstring were equivocal on the left. The current medication lists was not specified in the records provided. The patient has had an MRI on 12/24/09 of the lumbar spine that revealed degenerative changes at left L2/3, with disc bulge at L3/4, and artifact through L3-5 fusion site. An MRI on the left femur on 1/4/10 revealed no obvious mass and on 1/2/13 X-rays of the lumbar spine that revealed good position and alignment. The diagnostic imaging reports were not specified in the records provided. The patient's surgical history includes L3-L5 decompression and fusion. Any operative/ or procedure note was not specified in the records provided. The patient has received an unspecified number of the chiropractic visits for this injury.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiro 2 x 4:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-59.

**Decision rationale:** Per the MTUS guidelines regarding chiropractic treatment, "One of the goals of any treatment plan should be to reduce the frequency of treatments to the point where maximum therapeutic benefit continues to be achieved while encouraging more active self-therapy, such as independent strengthening and range of motion exercises, and rehabilitative exercises. The patient has received an unspecified number of the chiropractic visits for this injury. The notes from the previous rehabilitation sessions were not specified in the records provided. There was no evidence of significant progressive functional improvement from the previous chiropractic visits therapy that is documented in the records provided. The records submitted contain no accompanying current chiropractic evaluation for this patient. A valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program was not specified in the records provided. Furthermore, documentation of response to other conservative measures such as oral pharmacotherapy in conjunction with rehabilitation efforts was not provided in the medical records submitted. The request for Chiropractic treatment for the cervical spine, QTY: 8 sessions is not medically necessary.

**IM Toradol:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ketorolac (Toradol, generic available) Page(s): 72.

**Decision rationale:** According to the MTUS guidelines regarding Toradol (Ketorolac), "This medication is not indicated for minor or chronic painful conditions." Per the records provided the patient had chronic low back pain. Cited guidelines do not recommended Toradol for chronic painful conditions. In addition, any intolerance to oral medication is not specified in the records provided. Furthermore, documentation of response to other conservative measures such as oral pharmacotherapy in conjunction with rehabilitation efforts was not provided in the medical records submitted. The patient had sustained the injury in 1/17/2006 and any evidence of acute exacerbation of pain was not specified in the records provided. The medical necessity of the request for IM Toradol is not fully established in this patient.

**IF Unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

**Decision rationale:** Per the CA MTUS Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation (ICS) is "Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone." Per the cited guideline "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: - Pain is ineffectively controlled due to diminished effectiveness of medications; or - Pain is ineffectively controlled with medications due to side effects; or - History of substance abuse; or - Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or - Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction." Per the records provided, any indication listed above is not specified in the records provided. A recent detailed physical examination was not specified in the records provided. The records provided do not specify a response to conservative measures such as oral pharmacotherapy in conjunction with rehabilitation efforts for this injury. The patient has received an unspecified number of chiropractic visits for this injury. The previous PT visit notes are not specified in the records provided. Any evidence of diminished effectiveness of medications or intolerance to medications is not specified in the records provided. Furthermore, documentation of response to other conservative measures such as oral pharmacotherapy in conjunction with rehabilitation efforts was not provided in the medical records submitted. The medical necessity of the request for IF Unit is not fully established in this patient.

**QW full panel drug screen:**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 94-95.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43.

**Decision rationale:** Per the CA MTUS guideline cited above, drug testing is "Recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs." The current medication list was not specified in the records provided. Whether the patient is taking any prescribed opioid medication/ controlled substance, is not specified in the records provided. Any history of substance abuse was not specified in the records provided. The medical necessity of the request for QW full panel drug screen is not fully established in this patient.