

Case Number:	CM14-0199303		
Date Assigned:	12/09/2014	Date of Injury:	06/10/2008
Decision Date:	01/27/2015	UR Denial Date:	11/21/2014
Priority:	Standard	Application Received:	11/26/2014

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 Rehab, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 55-year-old male who reported an injury on 06/10/2008. The mechanism of injury was not provided. His diagnoses were noted to include lumbar disc displacement without myelopathy, fasciitis not otherwise specified, lumbar or lumbosacral disc degeneration, and encounter for long term use of other medications. Past treatments included trigger point injections and exercise. Diagnostic studies included an MRI of the lumbar spine without contrast, performed on 07/20/2009, which was noted to reveal degenerative disc disease and facet degenerative changes with normal sagittal alignment with no evidence of spondylolisthesis. On 12/15/2014, the injured worker complained of low back and left lower extremity pain, weakness over left lower extremity, and numbness over left leg. Physical examination revealed tenderness to palpation on the low back, radiation of pain with deep palpation, reduce muscle strength, straight leg raise positive on the left side, numbness to temperature and vibration on the left, and spinal spasm with palpation of left paralumbar muscles. Current medications included terazosin 5 mg, Toradol IM 30 mg/mL Tubex 60 mg/2 mL, Topamax 25 mg, Motrin 800 mg, oxycodone HCL 30 mg, tramadol HCL 50 mg, Robaxin 500 mg, and Celexa 20 mg. The treatment plan included left L5-S1 transforaminal epidural injection and refill of medications. A request was received for left L5-S1 transforaminal epidural steroid injection and Toradol IM 30 mg/cc - Tubex 60 mg 1 x week #10. The rationale for the request was not provided. The Request for Authorization form was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L5-S1 transforaminal epidural steroid injection: 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 Epidural Steroid Injections Page(s): 46.

Decision rationale: California MTUS Guidelines recommend an epidural steroid injection with documentation of radiculopathy by physical examination and corroborated by imaging studies and/or electrodiagnostic testing and the pain must be initially unresponsive to conservative treatment including exercise, physical therapy, NSAIDs, and muscle relaxants. There is no documentation of an MRI corroborating evidence of radiculopathy. The clinical notes indicate the injured worker has taken different medications for pain; however, there is no documentation with evidence of failed conservative care including physical therapy. As such, the request is not medically necessary.

Toradol IM 30mg/cc - Tubex 60mg 1 x week #10: 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 request for Toradol IM 30mg/cc - Tubex 60mg 1 x week #10 not medically necessary. California MTUS Guidelines state that Toradol is not indicated for minor or chronic pain conditions. In addition, there was no rationale provided to as why the injured worker would need 1 injection a week x 10 weeks. As Toradol is not recommended by the guidelines, the request is not supported. Therefore, the request is not medically necessary.