

<b>Case Number:</b>	CM15-0222475		
<b>Date Assigned:</b>	11/18/2015	<b>Date of Injury:</b>	01/02/2012
<b>Decision Date:</b>	12/31/2015	<b>UR Denial Date:</b>	10/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Iowa, Illinois, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

### 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 53 year old female who sustained an industrial injury on 1-2-12. A review of the medical records indicates she is undergoing treatment for cervical spine sprain and strain with C3-4 4 millimeter left lateral disc protrusion causing mild to moderate left and mild right neuroforaminal stenosis, C4-5 5.2 left greater than right lateral disc protrusion causing mild to moderate left and mild right neuroforaminal stenosis, C5-6 3.8 millimeter disc protrusion causing mild bilateral neuroforaminal stenosis, and C6-7 4.5 millimeter disc protrusion causing mild to moderate bilateral neuroforaminal stenosis, cervical radiculopathy, and cervicogenic and migraine headaches. Medical records (7-27-15, 7-28-15, 9-3-15, 9-12-15, 9-16-15, and 10-2-15) indicate ongoing, worsening complaints of neck pain that radiates to bilateral upper extremities, affecting the left side more than the right. She reports associated numbness, tingling, and weakness of the left upper extremity, as well as migraine headaches. She presented to the emergency department on 9-16-15 with increased pain in the left shoulder and left elbow. She was provided with Medrol Dosepak and Norco. On 10-2-15, she presented to the provider's office with complaints of "progressive and severe" complaints of left-sided neck pain and left upper extremity pain, as well as "intense" headaches due to pain. She describes the pain as "burning, electrical, lancinating pain" with increased numbness, tingling, and weakness of the left upper extremity. She rates her pain "7 out of 10" with medications and "10 out of 10" without medications. The provider indicates that the injured worker states "slight improvement" in pain levels with increased weakness in the left upper extremity. The physical exam (10-2-15) reveals diffuse bilateral cervical paraspinous tenderness from C1-T4. Positive

compression test is noted. Spurling's maneuver is positive on the left. "2+" muscle spasms are noted. Range of motion of the cervical spine is diminished. The provider notes "areas of hyperpathia over the left deltoid" on the upper extremity exam. The motor exam reveals diminished strength in all muscles tested. Decreased sensation is noted in the left C5-6 dermatome "greater than C7, C8 dermatome". Diagnostic studies have included x-rays of the left shoulder and left elbow, as well as an EMG-NCV study of bilateral upper extremities. Treatment has included left C6-7 epidural steroid injections with no noted relief, a cortisone injection to the left elbow with no noted relief, acupuncture, chiropractic treatment, use of a TENS unit, a home exercise program, use of an arm sling and wrist brace, as well as medications. The treatment plan (10-2-15) includes an intramuscular Toradol injection due to "severe acute flare of symptoms", continuation of medications, a CT myelogram of the cervical spine, re-evaluation by a spine surgeon, and a new prescription for Dilaudid. The utilization review (10-16-15) includes requests for authorization of 1 intramuscular Toradol injection 60mg and a re-evaluation by a spine surgeon. Both requests were denied.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Intramuscular Toradol injection, 60 mg: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Ketorolac (Toradol®).

**Decision rationale:** Ketorolac/Toradol is an NSAID. MTUS does not specifically detail Ketorolac injection, but only in the context of oral NSAID usage. ODG states, "Ketorolac, when administered intramuscularly, may be used as an alternative to opioid therapy." The treatment notes document ongoing opioid therapy concurrent with IM Toradol injection due to worsening muscular pain, Toradol is an injectable NSAID that can decrease inflammation and pain. As such, the request for Intramuscular Toradol injection, 60 mg is medically necessary.

#### **Re-evaluation with spine surgeon: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Surgical Considerations.

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Office Visits.

**Decision rationale:** ODG states concerning office visits "Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of

medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self-care as soon as clinically feasible." ACOEM states regarding assessments, "The content of focused examinations is determined by the presenting complaint and the area(s) and organ system(s) affected." Further writes that covered areas should include "Focused regional examination" and "Neurologic, ophthalmologic, or other specific screening." The treating physician is referring the patient due to worsening symptoms. The treatment notes do detail what medications and symptoms are to be evaluated and treated by the specialist. As such, the request for Re-evaluation with spine surgeon is medically necessary at this time.