MAXIMUS Federal Services

Case Number:	CM15-0041460		
Date Assigned:	03/11/2015	Date of Injury:	08/13/2002
Decision Date:	04/22/2015	UR Denial Date:	02/27/2015
Priority:	Standard	Application Received:	03/04/2015

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: Texas, California
Certification(s)/Specialty: Family Practice

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 52-year-old female, who sustained an industrial injury on August 13, 2002. She reported an injury resulting in cervical fusion, post laminectomy syndrome cervical spine, occipital neuralgia, myofascial pain and migraine headaches. Treatment to date has included diagnostic studies, surgery, physical therapy and medications. On March 11, 2015, the injured worker reported that her neck and upper extremity pain was better. The patient has had pain in left upper extremity with weakness. Physical examination of the cervical spine revealed range of motion was decreased 50%, and negative all special tests, normal gait, reflexes, and normal sensory and motor examination. Per the doctor's note dated 2/18/15 patient had complaints of pain had a recent flare up and Physical examination of the cervical spine revealed tenderness on palpation negative all special tests, normal gait and reflexes and normal sensory and motor examination. She noted her physical therapy had been going well. The treatment plan included an interferential unit in lieu of physical therapy and continuing with pain management. The patient's surgical history includes revision of anterior cervical discectomy and fusion on 11/18/14. The patient has had X-ray and MRI of the cervical spine that revealed post surgical changes. The patient's other surgical history include thyroid and knee surgery. The patient had received trigger point injections and Toradol injection for this injury. The medication list include Alprazolam, Oxycodone, and Vicodin. She has had a urine drug toxicology test that was consistent

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine Chronic Pain Summary of Recommendations; Chronic Pain Disorders.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009) Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: Request: Interferential Unit 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. Pain is ineffectively controlled with medications due to side effects. History of substance abuse. Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment. 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. The records provided do not specify a response to conservative measures such as oral pharmacotherapy in conjunction with rehabilitation efforts for this injury. Patient has received an unspecified number of PT visits for this injury. The records submitted contain no accompanying current PT evaluation for this patient. Detailed response to previous conservative therapy was not specified in the records provided. 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. The medical necessity of the request for Interferential Unit is not fully established in this patient. Therefore, the request is not medically necessary.

Retrospective intramuscular Toradol injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine Chronic Pain Summary of Recommendations; Chronic Pain Disorders.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines California Medical Treatment Utilization Schedule (MTUS), 2009, Page 72 Ketorolac (Toradol, generic available) Page(s): 72.

Decision rationale: Retrospective intramuscular Toradol injection. According to MTUS guidelines regarding toradol (ketorolac). "This medication is not indicated for minor or chronic painful conditions."Per the records provided 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. She noted her physical therapy had been going well. On March 11, 2015 and 2/18/15, physical examination of the cervical spine revealed negative all special tests, normal gait and reflexes and normal sensory and motor examination. Any significant functional deficits of the cervical region that would require an intramuscular Toradol injection were not specified in the records provided. The medical necessity of the Retrospective intramuscular Toradol injection is not fully established in this patient. Therefore, this request is not medically necessary.