

<b>Case Number:</b>	CM14-0119888		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	04/15/2002
<b>Decision Date:</b>	10/21/2014	<b>UR Denial Date:</b>	07/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/30/2014

### 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 and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 61-year-old female was reportedly injured on 4/15/2002. The mechanism of injury was noted as a motor vehicle accident. The claimant underwent an ACDF at C4-C5 and C5-C6 in 2004, followed by a spinal cord stimulator implantation in 2007. She underwent an ACDF at C3-C4 in 2008. The most recent progress note, dated 6/11/2014, indicated that there were ongoing complaints of upper extremity pain. Physical examination demonstrated continuous involuntary movements tonic and clonic and rotation and tilting of her head to the left side with left shoulder, arm and neck elevation. There were patches of hypoesthesia, dysesthesia in the left arm with allodynia and hyperpathia. The left arm appeared colder than the right. Peripheral pulses were normal. It was difficult to assess the cervical region and left arm due to pain and involuntary movements. There was tenderness at the right hip and pelvis. CT of brain, dated 1/22/2014, was unremarkable. CT arthrogram of right shoulder, dated 1/22/2014, showed a full thickness tear of the supraspinatus tendon. CT of the cervical spine, dated 1/22/2014, showed cervical fusion at C3-C6, degenerative disease at C6-C7 and C7-T1. There was posterior neurostimulator device adjacent to the thecal sac in the cervical region. Diagnoses were torticollis/dystonia of the left upper extremity and probable reflex sympathetic dystrophy of the left arm. Previous treatment included cervical fusion, spinal cord stimulator, chiropractic treatment, physical therapy and medications. A request had been made for home care patient needs and a nurse to assist with the Toradol injections 60 mg (2ml vial) 1 - 2 a week or as needed, and a follow-up visit, which were not certified in the utilization review on 7/3/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home care patient needs a nurse to assist with the Toradol injections 60mg (2ml vial) 1-2 a week or as needed:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51 of 127..

**Decision rationale:** MTUS/ACOEM practice guidelines do not address intramuscular Toradol injections. The Official Disability Guidelines support intramuscular Toradol injections as an alternative to opiate therapy. Review of the available medical records indicates the clinician recommends a Toradol 60 mg injection once or twice a week by a home health nurse. The claimant has chronic pain since a work related injury in 2002 and several surgical procedures. According to the last progress note, she has worsening of vertigo and cannot tolerate traveling in a car. The CA MTUS guidelines do not support home health care for patients who are not homebound, on a part time or intermittent basis. Therefore, this request is not considered medically necessary.

**Follow up visit:** 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 Page(s): 78 of 127..

**Decision rationale:** The MTUS treatment guidelines support follow-up office visits for the ongoing review and documentation of pain relief, functional status and medication management. Review of the available medical records indicates the claimant has chronic upper extremity pain since a work related injury in 2003 but fails to document the patient's current medications. Given this lack of documentation, the request is not considered medically necessary.