

Case Number:	CM14-0182613		
Date Assigned:	11/07/2014	Date of Injury:	07/16/1993
Decision Date:	12/17/2014	UR Denial Date:	10/10/2014
Priority:	Standard	Application Received:	11/03/2014

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, has a subspecialty in Interventional Spine 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:

The patient is a 54 year old male with an injury date of 07/16/1993. The patient presents pain in his low back, radiating down his lower extremities bilaterally. The patient rates his pain as 5/10 with medication and 8-9/10 without medication. The patient presents limited range of lumbar motion. His lumbar flexion is 45 degrees and extension is 10 degrees. Examination reveals hypernocuity of the lumbosacral musculature with myospasms present greater on the right than on the left. The patient remains on modified work without changing his work statue. The patient is currently taking Lorecet, Protonix and Toradol. Diagnoses on 09/19/2014 consist of myofascial pain, intervertebral disc disease, and radiculitis resolving flare. The utilization review determination being challenged is dated on 10/10/2014. Treatment reports were provided from 05/23/2014 to 09/19/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lorecet 10/325 mg # 120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 88, 89, 78.

Decision rationale: The patient presents with pain and weakness in his lower back and lower extremities. The patient is status post (s/p) surgery at L3-4 and L4-5. The request is for Lorecet 10/325mg #120. Lorecet contains Hydrocodone bitartrate and acetaminophen. The patient has been utilizing Lorecet 10/325, 1p.o. q.i.d. since at least 05/23/2014. The patient states in progress report on 09/19/2014 that "the medication does improve his functional activities of daily living (ADL's) which allows him to participate in light housework and some mild yard work. He rates his pain as 5/10 on medications and without it is 8-9/10." MTUS guidelines pages 88 and 89 state, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. The review of the reports show pain scale describing analgesia and some general statement regarding ADL's. However, side effects and aberrant behavior are not discussed. The reports do not show urine toxicology, CURES or other discussion. Furthermore, no numerical scale or validated instruments are used depicting the patient's functional improvement with the use of opiates. Given the lack of sufficient documentation demonstrating efficacy for chronic opiate use, the request is not medically necessary.

Toradol 60 mg IM injection retrospective request DOS 9/19/2014: 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: The patient presents with pain and weakness in his lower back and lower extremities. The patient is s/p surgery at L3-4 and L4-5. The request is for Intramuscular injections of Toradol 60mg. The 07/24/2014 report indicates that the patient had a Toradol injection 60mg. The patient states in progress report on 09/19/2014 that "the pain has improved some since his last severe flare." MTUS Guidelines pages 72 state that "Ketorolac (Toradol, generic available): is not recommended for minor or chronic pain. Academic Emergency Medicine, Vol 5, 118-122, also does not support Toradol injection showing that oral ibuprofen was just as effective as Toradol for acute pain in ER setting." Toradol injections are not indicated for chronic or acute flare-up of chronic pain. The request is not medically necessary.