
Notice of Independent Medical Review Determination

Dated: 9/12/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/2/2013
Date of Injury: 5/16/2008
IMR Application Received: 7/24/2013
MAXIMUS Case Number: CM13-0002801

- 1) MAXIMUS Federal Services, Inc. has determined the request for Norco 10/325 #120 **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Toradol injections every 3 months as needed **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/24/2013 disputing the Utilization Review Denial dated 7/2/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/29/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for Norco 10/325 #120 **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Toradol injections every 3 months as needed **is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, 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 treatments and/or services at issue.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 2, 2013

“According to the records made available for review, this is a 45-year-old female patient. The patient most recently (5/31/13) presented with chronic low back pain with radiating symptoms; the patient complains of gastritis from pain medications and stress from pain. Physical examination revealed moderate tenderness to palpation with muscular spasm of the bilateral L4-5 and L5-S1 region; range of motion of the lumbar spine between 50-70% of the normal range; manual muscle testing of the lower extremity revealed diminished muscle strength 5-/5 in the bilateral hip flexion, 4/5 in the bilateral knee extension and 5-/5 in the bilateral ankle dorsiflexion and plantar flexion; SLR positive in the bilateral lower extremities at 45 degrees. Current diagnoses include lumbar degenerative spondylosis, lumbar facet syndrome with chronic lumbago, most significant at L4-5 and L5-S1, left ankle sprain/strain, chronic reactive clinical depression, and abdominal pain with colonostomy. Treatment to date includes medication, radiofrequency. Treatment requested is Norco 10/325 #120, Toradol inj q 3 mo, and Prilosec 20mg #60.”

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application for Independent Medical Review (received 7/24/13)

- Utilization Review Determination (dated 7/2/13)
- Medical Records from [REDACTED], M.D. Pain Management (dated 6/4/12-5/31/13)
- Medical Records from [REDACTED], MD, PC (dated 7/2/12-2/18/13)
- EMG/NCV Results/Report from [REDACTED] (dated 6/12/12)
- Operative Reports from [REDACTED] (dated 10/11/12-11/15/12)
- Toxicology Screening from [REDACTED] (dated 3/25/13)
- Medical Records from [REDACTED] (dated 1/22/13)
- Physician's Supplemental Report from [REDACTED], MD (dated 10/31/12)
- Homecare Evaluation from [REDACTED] (dated 4/6/13)
- MRI of Right Hip from [REDACTED] (dated 8/3/12)
- MTUS Chronic Pain Medical Treatment Guidelines (2009), pages 79-80, 81
- Official Disability Guidelines (ODG) (2009), Ketorolac (Toradol, Generic Available):10mg

1) Regarding the request for Norco 10/325 #120:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines (2009), pgs. 79-81, part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator applicable and relevant to the issue at dispute.

Rationale for the Decision:

On 5/16/2008 the employee sustained an injury to the abdomen and low back. Medical records submitted and reviewed indicate treatment has included: hernia and colostomy repair, radiofrequency neurotomy, EMG/NVC, pain medications, a walker and home exercise. A reviewed medical report dated 5/31/13 indicates the employee continues to experience low back pain and gastritis. A request was submitted for Norco 10/325 #120 and Toradol shots every 3 months.

MTUS Chronic Pain Treatment Guidelines indicate that opioids should be given from a single practitioner, and the lowest dose should be prescribed to improve pain and function. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. A submitted medical record dated 05/31/2013 reports that the employee had a reduction in pain with medications from 8-9/10 reducing down to 4-5/10 on a pain scale of 0/10. The records reviewed document the employee was stable on the prescribed pain medication regimen, and has been following a home exercise program. The request for Norco 10/325 #120 **is medically necessary and appropriate.**

2) Regarding the request for Toradol injections every 3 months:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) (current version), Pain Chapter, Ketorolac (Toradol®) section, a Medical Treatment Guideline (MTG) not part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found no section of the MTUS to be applicable and relevant to the issue at dispute. The Expert Reviewer found the guidelines used by the Claims Administrator applicable and relevant to the issue at dispute.

Rationale for the Decision:

On 5/16/2008 the employee sustained an injury to the abdomen and low back. Medical records submitted and reviewed indicate treatment has included: hernia and colostomy repair, radiofrequency neurotomy, EMG/NVC, pain medications, a walker and home exercise. A reviewed medical report dated 5/31/13 indicates the employee is experiencing low back pain and gastritis. A request was submitted for Norco 10/325 #120 and Toradol shots every 3 months.

The Official Disability Guidelines recommend that Toradol injections be used as an option to corticosteroid injections with up to three injections. A submitted progress note dated 5/31/13 documents that the employee has responded well to Toradol injections, which stabilized flare-up exacerbations. However, the request was submitted on the presumption that the employee will continue to have flare-up exacerbations every 3 months. The medical records reviewed do not indicate the intended duration of these injections nor do they provide a clear rationale for continued Toradol injections every 3 months. The request for Toradol injections every 3 months **is not medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.