

<b>Case Number:</b>	CM13-0049349		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	06/27/2002
<b>Decision Date:</b>	03/20/2014	<b>UR Denial Date:</b>	10/08/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/07/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she 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 Texas. 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 physician 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 48-year-old male who reported an injury on 06/27/2002. The mechanism of injury was not provided for review. The patient developed chronic low back pain that was managed with medications to include ibuprofen and Lidoderm patches and Norco. The patient's most recent clinical evaluation revealed that the patient had low back pain rated 7/10. It is noted that the patient is able to go to the gym twice a week and is walking four (4) times a week. The patient's medical history does include type II diabetes. The patient's diagnoses included thoracic or lumbosacral neuritis, general symptoms, backache, and spinal fusion. The patient's treatment plan included continuation of medications and continued participation in a home exercise program.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Motrin 800 mg tablet, one (1) pill three (3) times a day, as needed:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines California Code of Regulations, Title 8, Effective July 18, 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Non-steroidal anti-inflammatory agents (NSAIDs) Page(s): 111.

**Decision rationale:** The Chronic Pain Guidelines recommend the use of anti-inflammatory drugs in the treatment of acute pain of the low back. However, the clinical documentation indicates that the patient has been using this medication for an extended duration of time. The guidelines also recommend medications used in the management of chronic pain are supported by documentation of pain relief and functional benefit. The clinical documentation submitted for review does not provide any evidence that the patient has any pain relief or functional benefit related to the medication usage. Therefore, continued use would not be indicated. As such, the request is not medically necessary or appropriate.

**Lidoderm 5% patches, apply to affected area (back) for twelve (12) hours/day:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines California Code of Regulations, Title 8, Effective July 18, 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** The clinical documentation submitted for review indicates that the patient has been using this medication for an extended duration of time. The Chronic Pain Guidelines recommend the continued use of this medication be supported by documentation of symptom relief and functional benefit. The patient's most recent clinical examination does not provide any evidence of functional benefit or symptom relief related to the use of this medication. Additionally, the documentation fails to provide evidence that the patient has not responded to first line treatments to include antidepressants and anticonvulsants. Therefore, continued use of this medication would not be supported. As such, the request is not medically necessary or appropriate.

**Glucophage 500 mg (other MD), take one (1) tablet two (2) times a day:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines California Code of Regulations, Title 8, Effective July 18, 2009..

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Diabetes Chapter, Glucagon-like peptide-1 (GLP-1) agonists.

**Decision rationale:** The Official Disability Guidelines recommend the use of this medication for non-insulin dependent diabetes. The clinical documentation indicates that the patient is diagnosed with this disease process; however, the clinical documentation does not provide any evidence of deficits related to this diagnosis to support the use of this medication. There is no documentation of any laboratory findings that would support the need for this medication. As such, the request is not medically necessary or appropriate.