

<b>Case Number:</b>	CM14-0001843		
<b>Date Assigned:</b>	01/22/2014	<b>Date of Injury:</b>	07/14/1990
<b>Decision Date:</b>	06/12/2014	<b>UR Denial Date:</b>	12/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/06/2014

### 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 Sports Medicine 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 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 injured worker is a 45 year old female who reported an injury on 07/14/1990. The mechanism of injury was not provided. Per the 01/06/2014 clinical note, the injured worker reported radiating low back and mid-back pain rated at 5/10. Objective findings included limited range of motion of the lumbar spine, negative straight leg raising, 5/5 motor strength and 2+ reflexes in the lower extremities. Medication regimen included Ibuprofen, Tramadol, Simvastatin, Paxil, Effexor, Benzapril, and Lantus. In the treatment plan, the provider recommended continued conservative therapy, Ibuprofen, and Motrin. The request for authorization form for Motrin and Ultram was submitted on 12/02/2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MOTRIN 800MG, #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS SPECIFIC DRUG LIST AND ADVERSE EFFECTS Page(s): 70-73.

**Decision rationale:** The California MTUS guidelines state NSAIDs are recommended as an option for short-term symptomatic relief of chronic low back pain. Regarding Ibuprofen, the

MTUS guidelines state that NSAIDs for mild to moderate pain may be recommended at 400 mg every 4-6 hours as needed, but doses greater than 400 mg have not provided greater relief of pain. However, higher doses are usually necessary for osteoarthritis. Per the 12/02/2013 clinical note, the injured worker had a prescription for Motrin 600mg twice daily. In the treatment plan, the provider noted a prescription for Ibuprofen 800mg three times daily was refilled. Per the 01/06/2014 clinical note, the injured worker reported she was using Ibuprofen 800mg twice daily. In the treatment plan, the provider recommended the injured worker continue both Ibuprofen and Motrin and an in-house prescription for Motrin 800mg twice daily was given. Therefore, the medical records provided do not clearly indicate the injured worker's prescribed doses. A rationale for having both Ibuprofen and Motrin was not provided. There is no documentation of sufficient clinical improvement to offset the risks associated with a higher dose. Therefore, the request for Motrin 800 mg # 60 is not medically necessary and appropriate.

**ULTRAM 50MG, #180 WITH 3 REFILLS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE; OPIOIDS FOR CHRONIC PAIN Page(s): 76-80; 80-82.

**Decision rationale:** The California MTUS guidelines state there should be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Measures of pain assessment that allow for evaluation of the efficacy of opioids and whether their use should be maintained include the following: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. In this case, the 01/06/2014 clinical note, reported that the injured worker had 5/10 radiating pain. It is unclear if this is with or without medications. There is a lack of documentation regarding a full pain assessment, appropriate medication use, functional improvement, and side effects to evaluate the efficacy of the medication. Therefore, the request for Ultram 50 mg # 180 with three refills is not medically necessary and appropriate.

**TRAMADOL 50MG, #180:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE; OPIOIDS FOR CHRONIC PAIN, 76-80; 80 Page(s): 76-80; 80-82.

**Decision rationale:** Regarding opioid management, the California MTUS guidelines state there should be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Measures of pain assessment that allow for evaluation of the efficacy of opioids and whether their use should be maintained include the following: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain

after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. In this case, the 01/06/2014 clinical note, stated the injured worker reported 5/10 radiating pain. It is unclear if this is with or without medications. There is a lack of documentation regarding a full pain assessment, appropriate medication use, functional improvement, and side effects to evaluate the efficacy of the medication. Therefore, the request for Tramadol 50 mg, # 180 is not medically necessary and appropriate.

**PENSAID SOLUTION #1 BOTTLE WITH 3 REFILLS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

**Decision rationale:** The California MTUS guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical NSAIDs may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. Diclofenac is indicated for the relief of osteoarthritis pain in joints that lend themselves to topical treatment. It has not been evaluated for treatment of the spine, hip, or shoulder. The medical records provided indicate the injured worker received a prescription for Pennsaid solution for the low back on 12/02/2013. The MTUS guidelines do not support the use of diclofenac for the spine. It is unclear if the injured worker experienced any pain relief or functional improvement from the solution to warrant continued use. In addition, the submitted request does not specify the site of application. Therefore, the request for Pensaid solution, 1 bottle with three refills is not medically necessary and appropriate.