

Case Number:	CM14-0159531		
Date Assigned:	10/01/2014	Date of Injury:	05/07/2010
Decision Date:	10/28/2014	UR Denial Date:	08/19/2014
Priority:	Standard	Application Received:	09/15/2014

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 Occupational Medicine and is licensed to practice in Iowa. 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 39 year old male with a date of injury of 5/7/2010. A review of the medical documentation indicates that the patient is undergoing treatment for chronic low back pain. Subjective complaints (8/19/2014) include moderate to severe low back pain, numbness in the R leg, and pain in the tailbone and buttocks. Objective findings (8/19/2014) include lumbar paraspinal spasm and tenderness and decreased spinal range of motion. The patient has received imaging studies including MRI (2013), which showed mild degeneration at L3-4, mild stenosis and protrusion at L4-5, and protrusion at L5-S1. Available medical documentation does not contain evidence of prior procedures. A utilization review dated 8/12/2014 did not certify the request for Hydrocodone-Acetaminophen 10/325 mg refill x5 and Ibuprofen 600 mg refill x4.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hydrocodone 10mg- Acetaminophen 325mg; 1 tablet orally every 4hrs as needed for pain with 5 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone OPIODS Page(s): 51, 74-95. Decision based on Non-MTUS Citation (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Opioids

Decision rationale: Hydrocodone is in the opioid class of medications. According to MTUS chronic pain guidelines, opioids should be used on a trial basis after failure of first-line therapies and re-evaluated regularly. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate use, and side effects. Satisfactory response to treatment should be indicated including decreased pain, increased functional status, or improved quality of life. ODG guidelines do not recommend use of opioids for low back pain except in short use for severe cases, not to exceed two weeks. The patient appears to have been on this medication for several months, which is in excess of what would be considered short-term therapy. The treating physician has not provided rationale for the extended use of this medication, and the medical documentation does not contain evidence of functional improvement or documented trials and failures of first line therapies. The treating physician also provides for a large amount of refills. The documentation states that the patient continues to have severe pain and decreased functional status despite this pain medication regimen. Therefore, the request for Hydrocodone 10mg-Acetaminophen 325mg; 1 tablet orally every 4hrs as needed for pain with 5 refills is not medically necessary and appropriate.

Ibuprofen 600mg, #90 with 4 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Meloxicam, NSAIDs, Page(s): 67-72.

Decision rationale: Ibuprofen is in the NSAID class of medications. According to MTUS chronic pain guidelines, NSAIDs are recommended for acute exacerbation of back pain at the lowest effective dose for the shortest amount of time. Side effects of concern include cardiovascular risk as well as renal, hepatic, and GI side effects with long-term use. It is unclear how long the patient has been on this medication, as available records only go back approximately two months. Although Ibuprofen could potentially be utilized as a first-line therapy in this patient for an acute exacerbation, the treating physician has not provided sufficient rationale regarding this utilization. Also, the large amount of refills indicates intent for long-term therapy rather than short-term. The documentation does not contain any additional evidence to clarify the reasoning for the use of this medication. Therefore, the request for Ibuprofen 600mg, #90 with 4 refills is not medically necessary and appropriate.