

<b>Case Number:</b>	CM14-0032333		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	01/19/2000
<b>Decision Date:</b>	07/22/2014	<b>UR Denial Date:</b>	02/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/14/2014

### 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 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 male who had a work related injury on 01/19/00. There was no submitted clinical documentation that described the mechanism of injury. Diagnosis is herniated disc L5-S1 and L4-5 with left lumbar radiculopathy. The most recent clinical note dated 02/12/14 indicated the injured worker ambulated with a cane. Decreased ankle reflexes, positive straight leg raise bilaterally. Positive sacroiliac joint provocative tests. Flexion 45 degrees, extension 15 degrees, and positive Lasegue's. There was no documentation of VAS, or increase in functional activities. Prior utilization review dated 02/25/14 was non-certified for the ibuprofen 800mg, Norco 7.5/325 mg, and Omeprazole 20 mg. The current request is for one prescription of ibuprofen 800mg #120, prescription for hydrocodone/acetaminophen 7.5/325mg #120, and prescription for Omeprazole 20mg #120.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 Prescription of Ibuprofen 800 mg #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSIDS, GI symptoms & cardiovascular Risks.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's Page(s): 67-73.

**Decision rationale:** The request for Ibuprofen is not medically necessary. The medical records provided for review does not support the request for ibuprofen. There is no documentation of any improvement while on the ibuprofen. According to the MTUS Chronic Pain Guidelines and Official Disability Guidelines, anti-inflammatories are the traditional first line of treatment to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. As such, the request is not medically necessary and appropriate.

**1 Prescription of Hydrocodone/Acetaminophen 7.5/325 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 Opiate's Page(s): 74-80. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**Decision rationale:** The clinical documentation that was submitted for review does not support the request for Hydrocodone/Acetaminophen 7.5/325 mg. There was no documentation of pain on the visual analog scale, or an increase in functional activities. As such medical necessity has not been established based on the MTUS Chronic Pain Guidelines and the Official Disability Guidelines.

**1 Prescription of Omeprazole DR 20 mg #120:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain. Protein pump inhibitors.

**Decision rationale:** The clinical documentation that was submitted for review does not support the request. There is no documentation of gastrointestinal distress. The Official Disability Guidelines do not support prophylactic use. Therefore, medical necessity has not been established.