

<b>Case Number:</b>	CM14-0070587		
<b>Date Assigned:</b>	07/14/2014	<b>Date of Injury:</b>	07/09/2008
<b>Decision Date:</b>	08/12/2014	<b>UR Denial Date:</b>	04/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/15/2014

### 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 Family Medicine 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 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 49 year old man who was injured at work on 7/9/2008. The injury was primarily to his back. He is requesting review of a denial for Ibuprofen 800 mg, #90 with 1 refill and Hydrocodone/APAP 5/325 mg, #60. Medical records corroborate ongoing care for his chronic back pain. He had presented on 5/12/2014 for an Independent Medical Review. At this visit he described continued back pain. His medications included: Ibuprofen 800 mg TID, Hydrocodone/APAP 5/325 mg QD prn, and Vicodin 500/5 mg prn. The diagnoses from this visit included: Lumbar Disc with Radiculitis; Low Back Pain; Myofascial Pain; Degenerative Disc Disease; and Sacroiliitis. Other treatment modalities included: physical therapy, heating pad, exercise, ice, and massage.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ibuprofen 800mg, #90 with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list and adverse effects, specific recommendations.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, Pages 67-68 Page(s): 67-68.

**Decision rationale:** The MTUS Chronic Pain Guidelines comment on the use of NSAIDs such as ibuprofen for the treatment of Chronic Low Back Pain. NSAIDs are recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. The medical records provided for review indicate that Ibuprofen is being used well beyond the time frame suggested in the MTUS Chronic Pain Guidelines. Further, the evidence in the medical records does not support efficacy of Ibuprofen in contributing to relief of the underlying pain. Given the long-term use of Ibuprofen and the lack of documentation of its efficacy, the request is not medically necessary and appropriate.

**Hydrocodone/APAP 5/325mg, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Pages 74-80 Page(s): 74-80.

**Decision rationale:** The MTUS Chronic Pain Guidelines provide criteria for the use of opioids. These criteria indicate the physician should establish a treatment plan. The treatment plan should include documentation of efforts to determine if there are reasonable alternatives to treatment with opioids. There should be an assessment as to whether there was improvement in symptoms of pain or function. There should be documentation on the red flags indicating that opioids were not helpful such as little or no relief with opioid therapy in the acute and subacute phases. For the continued use of opioids, the physician's actions should include: an ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. There should be documentation that the provider is following the 4 A's for Ongoing Monitoring to include: pain relief, side effects, physical and psychologic functioning, and the occurrence of any potentially aberrant or nonadherent behaviors. Further, there should be evidence of consultation with a multidisciplinary pain clinic if doses of opioids are required beyond 3 months. For chronic back pain, long-term efficacy is unclear (>16 weeks) and appears limited. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. Within the medical records provided for review, there is no evidence of a treatment plan, there is insufficient documentation in support of ongoing monitoring of the patient's opioid treatment, there is no evidence of consultation with a multidisciplinary pain clinic given the duration of the symptoms, and there is insufficient documentation to assess the efficacy of opioid therapy and reassessment of alternative therapy. In summary, there is insufficient justification to support ongoing treatment with opioids. As such, the request is not medically necessary and appropriate.