

Case Number:	CM15-0131484		
Date Assigned:	07/17/2015	Date of Injury:	10/15/2012
Decision Date:	08/14/2015	UR Denial Date:	06/09/2015
Priority:	Standard	Application Received:	07/07/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: North Carolina

Certification(s)/Specialty: Family Practice

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 28 year old male who sustained a work related injury October 15, 2012. He fell 10-12 feet off a motor home and suffered back and leg injuries. Past history included right knee surgery 2001 and 2005, fractured left arm 1990. According to a neurological physician's consultation, dated June 2, 2015, the injured worker presented with an MRI showing posterior L5-S1 broad-based disc osteophyte complex, disc fissuring. He complains of low back pain rated 6 out of 10. The pain in the back is described as 60% on the left 40% on the right and dull, throbbing and shooting across the bilateral iliac crest region with spasm. In the legs the pain is 60% on the left and 40% on the right but nearly equal with pain in the thighs, knees and feet. He has numbness at the right knee from the residual large incision from two knee surgeries in 2001 and 2005. There is no bowel or bladder dysfunction. He has been tripping from weakness on the left leg. Past treatment included physical therapy for 3-6 months in 2013-2014, epidural steroid injection in January 2014, and two radiofrequency nerve blocks in May 2014 and March 2015. Sensory examination shows pre-incision numbness around the left anterior knee incision and upper left calf, otherwise normal. There is mild weakness and ankle inversion and eversion 60-80% of normal, with plantar flexion and flexor digitorum weakness. Heel to toe raising is slightly diminished on the left. Diagnoses are spina bifida, mild; high sacral angle; leg length discrepancy with left shoe life for shortened left leg; right T7-T8. Recommendations included electrodiagnostic studies of the bilateral lower extremities, CT discogram of the lumbar spine, x-rays and thoracic spine consultation. At issue is the request for authorization for Ibuprofen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ibuprofen 600mg #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51, 72.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Page(s): 68-72.

Decision rationale: The California chronic pain medical treatment guidelines section on NSAID therapy states: Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008) Back Pain - Chronic low back pain: 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. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another. (Roelofs-Cochrane, 2008) See also Anti-inflammatory medications. Neuropathic pain: There is inconsistent evidence for the use of these medications to treat long term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain. This medication is recommended for the shortest period of time and at the lowest dose possible. The dosing of this medication is within the California MTUS guideline recommendations. The definition of shortest period possible is not clearly defined in the California MTUS. Therefore, the request is medically necessary.