

<b>Case Number:</b>	CM15-0132774		
<b>Date Assigned:</b>	07/20/2015	<b>Date of Injury:</b>	02/28/2014
<b>Decision Date:</b>	08/14/2015	<b>UR Denial Date:</b>	06/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/09/2015

### 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: Arizona, California  
 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 34 year old female, who sustained an industrial injury on 02/28/2014. She has reported injury to the low back. The diagnoses have included low back pain; displacement of lumbar intervertebral disc; and disc herniation at the L3-L4 level with compression and spinal stenosis. Treatment to date has included medications, diagnostics, trigger point injections, and physical therapy. Medications have included Voltaren ER, Orphenadrine ER, Hydrocodone/Acetaminophen, Hydrocodone/Ibuprofen, and Gabapentin. A progress note from the treating physician, dated 05/01/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of continued pain about her low back and radicular symptoms in the left lower extremity; and over the past two or three days, her pain has been quite severe and denies any new or recent trauma. Objective findings included tenderness to palpation as well as spasm bilaterally about the lumbar paraspinal musculature; she is very guarded in motion and ambulates with a walking cane; her active voluntary range of motion of the thoracolumbar spine is severely limited; upon performing the heel-and-toe walk, there is evidence of a slight left foot drop; straight-leg-raising test is positive bilaterally with the left being greater than the right; and motor exam of the lower extremities reveals weakness of the left ankle dorsiflexors and evertors. The treatment plan has included the request for retrospective Ibuprofen/Hydrocodone 200/7.5mg, #120, date of service: 05/01/2015; and retrospective injection tendon x2, Marcaine .5% 2 units, Ketoralac 2 units, Dexamethasone 2 units, performed: 05/01/2015.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Ibuprofen/Hydrocodone 200/7.5mg, #120 DOS: 05/1/2015: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain Chapter Opioids, criteria for use.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids/NSAIDS Page(s): 82-92, 67.

**Decision rationale:** Hydrocodone is a short acting opioid used for breakthrough pain. According to the MTUS guidelines, it is not indicated as 1st line therapy for neuropathic pain, and chronic back pain. It is not indicated for mechanical or compressive etiologies. It is recommended for a trial basis for short-term use. Long Term-use has not been supported by any trials. According to the guidelines, NSAIDs are recommended as a second-line treatment after acetaminophen. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain. NSAIDs are recommended as an option for short-term symptomatic relief. In this case, the claimant had been on Norco for several months. Routine documentation of pain scores was not noted. In addition, there was no mention of Tylenol failure. Chronic use of NSAIDs or opioids or in combination is not indicated. The request for Ibuprofen/Hydrocodone is not medically necessary.

**Retrospective Injection tendon x2; Marcaine .5% 2 units, Ketorlac 2 units, Dexamethasone 2 units performed: 05/1/2015: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**Decision rationale:** According to the ACOEM guidelines, trigger point injections are not recommended. Invasive techniques are of questionable merit. The treatments do not provide any long-term functional benefit or reduce the need for surgery. The claimant had undergone injections in the past. In addition, the claimant had undergone therapy and use of analgesics. Therefore the Marcaine .5% 2 units, Ketorlac 2 units, Dexamethasone 2 units injections on 05/1/2015 were not medically necessary.