

<b>Case Number:</b>	CM15-0168478		
<b>Date Assigned:</b>	09/09/2015	<b>Date of Injury:</b>	04/02/2004
<b>Decision Date:</b>	10/14/2015	<b>UR Denial Date:</b>	08/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/26/2015

### 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 (IW) is a 57-year-old male who sustained an industrial injury on 04-02-2004. He reported pain in his shoulders and knees. The injured worker was diagnosed as having pain in joint, shoulder region, and rotator cuff sprain and strain. Treatment to date has included right shoulder surgery (date not found) and left shoulder surgery (10-18-2012). A MRI of the right knee in 2012 showed no clear meniscus tear, and the worker was started in physical therapy for the right knee, and given orthovisc injections in the right knee x 2 (06-03-2015 and 06-17-2013). In the exam of 07-09-2015, the injured worker complains of chronic bilateral shoulder pain and right knee pain. The left shoulder pain is felt to be a result of overcompensation from the right shoulder surgery. His medications include Hydrocodone, Omeprazole, Ibuprofen, and Lexapro. His prior medications included Vicodin 5mg every 6 hours as needed for pain, Vicodin 7.5 /750 mg every six hours as needed for pain, Tylenol, and Zantac. Objectively, the worker has left shoulder and cervical range of motion restricted by pain in all directions; right knee range of motion limited by pain in all directions; nerve root tension signs negative bilaterally, and muscle strength is full in all limbs. He has a release to work with restrictions on both shoulder and knee. The treatment plan includes physical therapy and potential left shoulder surgery. A request for authorization was submitted (07/17/2015) for Hydrocodone 10/325mg, 1 tablet by mouth 4 times a day, #120; Omeprazole 20mg, 1 tablet by mouth every day, #30; Ibuprofen 600mg, #60; and Follow-up office visit in 4 weeks. A utilization review decision (08-04-2015) approved the Omeprazole, Hydrocodone and a follow-up visit but non-certified the Ibuprofen request.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Ibuprofen 600mg, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 47. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

**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 opioids states for ongoing management: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to nonopioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of Opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids (a) If the patient has returned to work, (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documented significant improvement in VAS scores for significant periods of time. There are no objective measurements of improvement in function. Therefore, not all criteria for the ongoing use of opioids have been met and the request is not medically necessary.

