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| Case Number: | CM15-0117632 | | |
| Date Assigned: | 07/06/2015 | Date of Injury: | 12/09/2010 |
| Decision Date: | 08/06/2015 | UR Denial Date: | 05/20/2015 |
| Priority: | Standard | Application Received: | 06/18/2015 |

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 65 year old male, who sustained an industrial injury on December 9, 2010. The injured worker reported a fall resulting in left hip and back pain with numbness in the left leg to the toes. Several documents within the submitted medical records are difficult to decipher. The injured worker was diagnosed as having cervical and lumbar disc disease with radiculopathy, lumbar facet syndrome and left sacroiliac joint strain/sprain. Treatment to date has included magnetic resonance imaging (MRI), physical therapy, chiropractic treatment, home exercise program (HEP) and medication. A progress note dated May 12, 2015 provides the injured worker complains of neck and back pain. He rates the pain 7/10. Physical exam notes cervical and lumbar tenderness with spasm. There is positive compression test of left upper extremity and positive left straight leg raise. The plan includes epidural steroid injection, follow-up and Motrin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motrin 800mg 1 QID PRN #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
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Decision rationale: Regarding the request for Motrin (ibuprofen), Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that the medication is providing any specific analgesic benefits (in terms of percent pain reduction or reduction in numeric rating scale) or any objective functional improvement. In the absence of such documentation, the currently requested Motrin (ibuprofen) is not medically necessary.