

Case Number:	CM15-0129041		
Date Assigned:	07/15/2015	Date of Injury:	07/17/2002
Decision Date:	08/11/2015	UR Denial Date:	06/11/2015
Priority:	Standard	Application Received:	07/02/2015

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: New Jersey, Alabama, California

Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 56 year old female, who sustained an industrial injury on July 17, 2002. The initial symptoms reported by the injured worker are unknown. The injured worker was diagnosed as having lumbar degenerative disc disease, right sacroiliac joint pain and piriformis syndrome and right foot drop. Treatment to date has included medications, physical therapy and steroid injections. On May 28, 2015, the injured worker complained of lower back and bilateral leg pain. She described the pain as a grabbing sensation in the right lower back, right hip, right buttock and over the greater trochanter. She reported that activity and mobility were declining. The treatment plan included an injection in the right sacroiliac joint and greater trochanter, medications and a follow-up visit. On June 11, 2015, Utilization Review non-certified the request for Ibuprofen 800 mg #90, citing California MTUS Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ibuprofen 800mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
NONSELECTIVE NSAIDS Page(s): 107.

Decision rationale: According to MTUS guidelines, Chronic Pain Medical Treatment Guidelines chapter, NON-SELECTIVE NSAIDS section, Ibuprofen is indicated for pain management of breakthrough of neck or back pain. The medication should be used at the lowest dose and for a short period of time. There is no documentation that the patient developed exacerbation of his pain. There is no documentation that the lowest dose and shortest period is used for this patient. Although the patient developed a chronic pain that may require Ibuprofen, there is no documentation that the provider recommended the lowest dose of Ibuprofen for the shortest period of time. There is no documentation of pain and functional improvement with previous use of Ibuprofen. Therefore, the prescription of Ibuprofen 800mg #90 is not medically necessary.