

<b>Case Number:</b>	CM13-0036563		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	09/06/2001
<b>Decision Date:</b>	02/28/2014	<b>UR Denial Date:</b>	10/10/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/21/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Neurology has a subspecialty in Neuromuscular Medicine and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

██████████ is a 56 year old woman who sustained a work related injury on September 6, 2001. Subsequently, the patient developed but chronic bilateral knee and hand pain. The patient underwent a left knee total arthroscopy on October 1, 2012, and right knee surgery on February 25, 2008. According to the progress notes of September 10, 2013 written by ██████████, the patient developed ongoing bilateral knee and hand pain as well as a progressive decrease in grip strength. Physical examination demonstrated atrophy of the thenar eminence muscles bilaterally, tenderness to palpation over the medial and lateral joint line of the knees bilaterally. However stability of both knees was documented by the note of ██████████ on September 6, 2013. The patient was diagnosed with carpal tunnel syndrome, cervical sprain, lumbar sprain, bilateral knee disorder, and obesity. The patient was previously treated with 24 sessions of physical therapy, unknown number of aqua therapy sessions and unknown number of acupuncture sessions. She was also treated with pain medications including hydrocodone, Neurontin, tramadol and cyclobenzaprine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol 150 mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 113.

**Decision rationale:** According to MTUS guidelines, Ultram (Tramadol) is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules: <(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 non adherent) 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> there is no clear evidence of objective and recent functional and pain improvement with previous use of opioids. Therefore, Tramadol is not medically necessary at this time.

**1 Pro-hinged knee brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340.

**Decision rationale:** According to MTUS guidelines, Knee Complaints, Activity Alteration, page 340, < A brace can be used for patellar instability, anteriorcruciate ligament (ACL) tear, or medical collateral ligament (MCL) instability although its benefits may be more emotional (i.e., increasing the patient's confidence) than medical. Usually a brace is necessary only if the patient is going to be stressing the knee under load, such as climbing ladders or carrying boxes. For the average patient, using a brace is usually unnecessary. In all cases, braces need to be properly fitted and combined with a rehabilitation program.> There is no documentation of knee instability and the patient file. Therefore, the prescription of 1 Pro-hinged knee brace is not medically necessary.