

Case Number:	CM13-0060454		
Date Assigned:	04/23/2014	Date of Injury:	03/09/2011
Decision Date:	12/17/2014	UR Denial Date:	11/19/2013
Priority:	Standard	Application Received:	12/03/2013

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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in the District of Columbia and Virginia. 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/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:

This 50 year old male sustained a work related injury to the left knee on 03/09/2011. According to an Agreed Medical Evaluation (AME) performed on 06/05/2013, the injury occurred on 03/19/2011 when the injured worker slipped and fell on the left knee during the course of his usual duties as a hotel auditor and front desk agent. According to the AME, the injured worker underwent a left knee arthroscopic procedure on 12/10/2012 that revealed a grade IV osteochondral lesion of the left knee. This surgical report was not submitted for review. Documentation of radiographic imaging was also not submitted for review. He remained temporarily totally disabled. His medication regimen at the time evaluation was on an as needed basis and included Cardiovisc, Dyflonic, Tylenol, Hydrocodone and Tramadol. He complained of bilateral knee pain that was described as a constant throbbing pain in the left knee and a "knot" sensation in the right knee that had increased since his prior examination. As of an office visit on 10/09/2013, the injured worker complained of persistent left knee pain and continued swelling. A physical examination revealed well healed arthroscopic portals of the left knee. There was tenderness about the joint line. He could extend to 0 degrees and flex to 120 degrees. The Homan maneuver was negative. The calf was not tender to palpation. Crutches were used for ambulation. Diagnoses included left knee full thickness grade IV left femoral osteochondral lesion status post arthroscopy 12/10/2012, right knee strain and stress syndrome. The treatment plan included left knee surgery, Norco for break through pain, Ultram and an orthopaedic re-evaluation in six weeks. The injured worker remained temporarily totally disabled.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg 1 po q 6 prn #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid, Specific Drug List Page(s): 91.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75, 91.

Decision rationale: Per MTUS, Hydrocodone/Acetaminophen: Indicated for moderate to moderately severe pain. Note: there are no FDA-approved hydrocodone products for pain unless formulated as a combination. Side Effects: See opioid adverse effects. Analgesic dose: The usual dose of 5/500mg is 1 or 2 tablets PO every four to six hours as needed for pain (Max 8 tablets/day). For higher doses of hydrocodone (>5mg/tab) and acetaminophen (>500mg/tab) the recommended dose is usually 1 tablet every four to six hours as needed for pain. Hydrocodone has a recommended maximum dose of 60mg/24 hours. The dose is limited by the dosage of acetaminophen, which should not exceed 4g/24 hours. The patient had been on this medication for about 2 years and a process of weaning was recommended in 2013. The patient should be able to stop this medication and it would not be medically indicated. The request is considered not medically necessary.

Ultram 50mg 1 PO Q 6 prn #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid , Specific Drug List Page(s): 93-94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93-94.

Decision rationale: Per MTUS, Tramadol (Ultram; Ultram ER; generic available in immediate release tablet): Tramadol is a synthetic opioid affecting the central nervous system. Tramadol is not classified as a controlled substance by the DEA. Side Effects: Dizziness, nausea, constipation, headache, somnolence, flushing, pruritus, vomiting, insomnia, dry mouth, and diarrhea. Tramadol may increase the risk of seizure especially in patients taking SSRIs, TCAs and other opioids. Do not prescribe to patients that at risk for suicide or addiction. Warning: Tramadol may produce life-threatening serotonin syndrome, in particular when used concomitantly with SSRIs, SNRIs, TCAs, and MAOIs, and triptans or other drugs that may impair serotonin metabolism. Analgesic dose: Tramadol is indicated for moderate to severe pain. The immediate release formulation is recommended at a dose of 50 to 100mg PO every 4 to 6 hours (not to exceed 400mg/day). This dose is recommended after titrating patients up from 100mg/day, with dosing being increased every 3 days as tolerated. For patients in need of immediate pain relief, which outweighs the risk of non-tolerability the initial starting dose, may be 50mg to 100mg every 4 to 6 hours (max 400mg/day). Ultram ER: Patient currently not on immediate release Tramadol should be started at a dose of 100mg once daily. The dose should be titrated upwards by 100mg increments if needed (Max dose 300mg/day). Patients currently on immediate release Tramadol calculate the 24-hour dose of IR and initiate a total daily dose of ER

rounded to the next lowest 100mg increment (Max dose 300mg/day). The patient had been on this medication for about 2 years and a process of weaning was recommended in 2013. The patient should be able to stop this medication and it would not be medically indicated. The request is not medically necessary.