

Case Number:	CM14-0137120		
Date Assigned:	09/05/2014	Date of Injury:	01/18/2008
Decision Date:	10/29/2014	UR Denial Date:	07/23/2014
Priority:	Standard	Application Received:	08/25/2014

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 Family Medicine and is licensed to practice in Colorado. 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:

The 72 year old male permanently partially disabled following injury 1/18/2008, returns to treatment 1/2014 for ongoing low back pain radiating into right leg. Patient injury occurred 1/18/2008 when he was driving a work vehicle, wearing his seat belt, and was hit on the driver's side in an intersection. At that time, he had neck pain, low back pain, right shoulder pain and right knee pain. He took medications (not specified in the records supplied), and underwent therapy after the initial accident. He had right shoulder surgery about 4 years after the accident, but still notes pain 3-4/10 and subjective instability in the right shoulder as of his 1/2014 visit with treating physician. He also continues to have right knee pain though only occasional, rated 5/10, with associated swelling / popping / clicking. He still has frequent neck pain, rated 3-4/10, radiating to shoulders with no numbness or tingling in the arms. He does have headaches. Patient's primary concern, per the records, is constant low back pain, radiating to right leg with numbness / tingling / weakness in right leg. He denies bowel or bladder dysfunction, and rates the pain 5/10. Previous C-spine MRI results were not provided for review. Previous L-spine MRI results showed disc bulges, per summary in the notes, but no report is available for me to review. Patient indicated to treating physician that epidural steroid injection has previously been recommended to him but he refuses. Physical therapy requested and approved 2 visits after 1/2014 physician evaluation which showed decreased range of motion and tenderness in lumbar spine region. Updated L-spine MRI 4/16/2014 shows straightening of low back, disc dessication at multiple levels and disc bulge, pushing on the cal sac at L3-L4, L4-L5, and L5-S2.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol (dosage and quantity unspecified): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PAIN INTERVENTIONS AND TREATMENTS Page(s): 78-80 AND 113.

Decision rationale: Per the guidelines, opioids are considered to be second line therapy, and no documentation was supplied that patient had tried other medications. No records were available for review that indicated patient's level of improvement in pain or function on his current regimen, and that current regimen was not specified in the notes of the treating physician. Patient did not seem to have any improvement over the 6 month period for which notes were provided, though the treating physician did state that patient was better when on the medications. That was not quantified or verified with a validated assessment tool, and it is was not made clear which medications helped him and how those medications helped him. Per the Guidelines, when prescribing opioids, several issues need to be considered / documented and re-addressed with ongoing use: 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. The above can be summarized as " The 4 A's for Ongoing Monitoring:" analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. Opioid use, after patient has failed acetaminophen and/or non-steroidal anti-inflammatory drugs, has been shown to be effective for chronic back pain, but typically no longer than 16 weeks, and limited in effects on function. Tramadol, a centrally acting opioid, has been shown to improve chronic back pain better than placebo in 3 studies, but they were small studies and did not show any improvement in function. As the guidelines make it clear that ongoing assessment and evaluation should continue once opioids prescribed, patient does require follow up visits to discuss pain issues and treatment, which should be every 2 weeks for 2-4 months, then every 1-2 months based on needs. Per the records reviewed (many of which are duplicates), there is no clear documentation that patient was ever prescribed Tramadol prior to this request for Tramadol, though the Utilization Review physician noted that patient had been approved for this medication in the past. If patient has been taking this medication, there is no documentation of the ongoing monitoring parameters that he should be discussing at visits, and no routine follow-up scheduled as of 6/2014 visit when treating physician, ordered Tramadol and documented "follow up prn." It IS documented that whatever medications he was prescribed he had "run out of," so weaning from Tramadol would not be needed. As there is no documentation that patient has been monitored or will be monitored on this opioid as recommended by the Guidelines, and no documentation of patient improvement on this opioid the request for Tramadol, then is not medically necessary.

Relafen (dosage and quantity unspecified): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PAIN INTERVENTIONS AND TREATMENTS Page(s): 67-68, 70, 72.

Decision rationale: Per the Guidelines, non-steroidal anti-inflammatory drugs are recommended at the lowest effective dose for the shortest period needed, in moderate to severe pain from osteoarthritis, chronic low back pain, and exacerbations of chronic low back pain. However, acetaminophen may be considered as first line for those with significant gastrointestinal risk factors or cardiovascular / renal concerns, due to adverse effects that can occur with, non-steroidal anti-inflammatory drugs in regard to those systems. There is no evidence to suggest that one non-steroidal anti-inflammatory drug is better than another at relieving pain, though some have less documented gastrointestinal effects and others have possibly less cardiovascular effects, though these possible differences are disputed. There is no evidence based information available that shows efficacy long term with non-steroidal anti-inflammatory drug treatment for pain and there are no known effects long term on overall function when using non-steroidal anti-inflammatory drug treatment. As above, a primary concern in choosing non-steroidal anti-inflammatory drugs instead of acetaminophen, would be risks for gastrointestinal events, which include: 1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). If patient has risk factors for gastrointestinal event, then consider: 1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44) When considering non-steroidal anti-inflammatory drugs for chronic back pain, as in this case, it is important to note that recent Cochrane reviews found no difference in pain levels when treated with non-steroidal anti-inflammatory drugs versus placebo, and no difference between treatment with non-steroidal anti-inflammatory drugs and acetaminophen. Furthermore, acetaminophen caused fewer side effects and adverse events than non-steroidal anti-inflammatory drugs or other pain relievers. (Roelofs-Cochrane, 2008) Per the records supplied, there is no documentation of previous prescription for Relafen, a non-steroidal anti-inflammatory drug, though Utilization review physician indicates it was previously approved for patient. However, even if patient has taken in the past, there is no documentation of quantifiable measurement of functional improvement with it and no mention of assessment for pain improvement when taking it. Furthermore, given patient's age, he is at increased of gastrointestinal event, so acetaminophen should be first line therapy. I find no documentation in the records supplied that indicate patient has tried acetaminophen for pain. Due to patient's risk factor and lack of documentation of previous use of non-steroidal anti-inflammatory drug versus acetaminophen, the Relafen is not medically indicated.