MAXIMUS Federal Services

Case Number:	CM14-0176880		
Date Assigned:	10/30/2014	Date of Injury:	12/06/2002
Decision Date:	12/05/2014	UR Denial Date:	10/16/2014
Priority:	Standard	Application Received:	10/24/2014

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 Occupational 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 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 case is a 60 year old female with a date of injury on 12/6/2002. A review of the medical records indicate that the patient has been undergoing treatment for shoulder arthroscopy, shoulder impingement syndrome, carpal tunnel, and undefined rheumatoid condition. Subjective complaints (4/17/2014, 7/17/2014) include bilateral shoulder pain with radiation into the trapezium, intermittent back pain, and notes functional improvement with medication. Objective findings (4/17/2014, 7/17/2014) include positive impingement sign left shoulder, and tenderness to posterior neck. Treatment has included ambien (since at least 4/2014), Ultram (since at least 4/2014), Naproxen, shoulder surgery, and carpal tunnel release.A utilization review dated 10/16/2014 non-certified the following:- Ultram 50 mg 1 tab q8h #120 with 2 refills due to lack of documented breakthrough pain severe enough for this medication- Ambien 10 mg 1hs prn #10 with 2 refills due to ongoing chronic use and prior recommendation to wean.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultram 50 mg 1 tab q8h #120 with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Opioids, Tramadol, Ultram Page(s): 74-96, 113, 123. Decision based on Non-MTUS Citation (ODG) Pain (Chronic) - Medications for acute pain (analgesics), Tramadol (UltramÂ®)

Decision rationale: Ultram is the brand name version of Tramadol, which is classified as central acting synthetic opioids. MTUS states regarding tramadol that "A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." ODG further states, "Tramadol is not recommended as a first-line oral analgesic because of its inferior efficacy to a combination of Hydrocodone/ acetaminophen."The treating physician did not provide sufficient documentation that the patient has failed a trial of non-opioid analgesics at the time of prescription or in subsequent medical notes. As written, the request is for 120 days of medication without any interim evaluation or monitoring, which is excessive. Additionally, no documentation was provided which discussed the setting of goals for the use of tramadol prior to the initiation of this medication. As such, the request for Ultram 50mg 1 tab q8h #120 with 2 refills is not medically necessary.

Ambien 10 mg 1hs prn #10 with 2 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter, Insomnia Treatment

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines pain, Zolpidem, insomnia treatment

Decision rationale: The CA MTUS silent regarding this topic. ODG states that Zolpidem is a prescription short acting non-benzodiazepine hypnotic, which is approved for short-term treatment of insomnia. In this case, the patient has been taking this medication as early as 4/2014, which is not considered short term treatment. There has been no discussion of the patient's sleep hygiene or the need for variance from the guidelines, such as "a) Wake at the same time everyday; (b) Maintain a consistent bedtime; (c) Exercise regularly (not within 2 to 4 hours of bedtime); (d) Perform relaxing activities before bedtime; (e) Keep your bedroom quiet and cool; (f) Do not watch the clock; (g) Avoid caffeine and nicotine for at least six hours before bed; (h) Only drink in moderation; (i) Avoid napping." Medical documents also do not include results of these first line treatments, if they were used in treatment of the patient's insomnia. ODG additionally states "The specific component of insomnia should be addressed: (a) Sleep onset; (b) Sleep maintenance; (c) Sleep quality; (d) Next-day functioning." Medical documents provided do not detail these components. As such, the request for Ambien 10 mg 1hs prn #10 with 2 refills is not medically necessary at this time.