

Case Number:	CM14-0023706		
Date Assigned:	06/13/2014	Date of Injury:	05/20/2009
Decision Date:	07/24/2014	UR Denial Date:	02/05/2014
Priority:	Standard	Application Received:	02/25/2014

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 Practice 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:

The 38 year old female claimant sustained a work related injury on 5/20/09 involving bilateral wrists/hands and arms. She has a diagnosis of left triggering thumb and right index and middle trigger fingers. In addition she had bilateral trapezial pain along with neck pain. For most of 2013 she had used NSAIDs for pain relief. She had undergone steroid injections of the fingers and surgical release of the trigger fingers. A progress note on November 26, 2013 indicated she had continued pain while on Naprosyn and was changed to Ultracet 1 tabled twice daily and difficulty sleeping due to pain for which she was prescribed Ambien 10 mg at night. A request was made subsequently to continue the Ambien and Tramadol until April 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

AMBIEN 10MG 1 TABLET QHS PRN #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Insomnia Medications.

Decision rationale: The MTUS and ACOEM guidelines do not comment on insomnia medications. According to the ODG guidelines: Recommend that treatment be based on the etiology, pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. The specific component of insomnia should be addressed: Sleep onset, sleep maintenance, sleep quality and next-day functioning. There are four main categories of pharmacologic treatment: Benzodiazepines, non-benzodiazepines, melatonin and melatonin receptor agonists and over-the-counter medications. The majority of studies have only evaluated short-term treatment of insomnia; therefore more studies are necessary to evaluate the efficacy and safety of treatments for long-term treatment of insomnia. In 2007, the FDA requested that manufacturers of all sedative-hypnotic drugs strengthen product labeling regarding risks (i.e. severe allergic reactions and complex sleep-related behaviors, such as sleep driving). It is recommended that treatments for insomnia should reduce time to sleep onset, improve sleep maintenance, avoid residual effects and increase next-day functioning. Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. Longer-term studies have found Ambien CR to be effective for up to 24 weeks in adults. The medication should be discontinued if the latter occurs. Abrupt discontinuation may lead to withdrawal. Adults who use zolpidem have a greater than 3-fold increased risk for early death, according to results of a large matched cohort survival analysis. Due to adverse effects, FDA now requires lower doses for zolpidem. The dose of zolpidem for women should be lowered from 10 mg to 5 mg for IR products. In this case, the claimant had been prescribed Ambien for several months. The dose provided exceeds that recommended for women and the length of time short acting Ambien is recommended. In addition, no other evaluations were performed to determine the nature of the sleep disturbance. The Ambien prescribed is not medically necessary.

ULTRACET 1 TABLET BID PRN #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, pg. 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 82-94.

Decision rationale: Ultracet contains Tramadol and Tylenol. According to the MTUS guidelines: Opioid analgesics and Tramadol have been suggested as a second-line treatment A recent consensus guideline stated that opioids could be considered first-line therapy for the following circumstances: Prompt pain relief while titrating a first-line drug, treatment of episodic exacerbations of severe pain and treatment of neuropathic cancer pain. Tramadol is a synthetic opioid affecting the central nervous system. The immediate release formulation is recommended at a dose of 50 to 100mg orally every 4 to 6 hours. 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. 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. 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. Treatment of chronic lumbar root pain: A limitation of current studies is that there are virtually no repeated dose analgesic trials for neuropathy secondary to lumbar radiculopathy. A recent study that addressed this problem found that chronic lumbar radicular pain did not respond to either a tricyclic antidepressant or opioid in doses that have been effective for painful diabetic neuropathy or postherpetic neuralgia. Morphine was the least effective treatment (reducing leg and back pain by 1-7% compared to placebo). Sample size and drop out rate was a limitation. Not recommended as a first-line therapy for osteoarthritis. Short-term use: Recommended on a trial basis for short-term use after there has been evidence of failure of first-line non-pharmacologic and medication options (such as acetaminophen or NSAIDs) and when there is evidence of moderate to severe pain. Also recommended for a trial if there is evidence of contraindications for use of first-line medications. Weak opioids should be considered at initiation of treatment with this class of drugs (such as Tramadol, Tramadol/acetaminophen, hydrocodone and codeine), and stronger opioids are only recommended for treatment of severe pain under exceptional circumstances (oxycodone, oxycodone, hydromorphone, fentanyl, morphine sulfate). Benefits of opioids are limited by frequent side effects (including nausea, constipation, dizziness, somnolence and vomiting). In this case, the claimant was subsequently prescribed longer-term use of Tramadol. It is intended for short-term use. There is no documentation of pain response or scale in after initiating Tramadol (Ultracet). There is also no trial basis for using Acetaminophen or Tramadol alone. Based on the clinical information and the guidelines above, the continuation of Ultracet is not medically necessary.