

Case Number:	CM14-0070159		
Date Assigned:	07/14/2014	Date of Injury:	04/27/2008
Decision Date:	09/19/2014	UR Denial Date:	05/05/2014
Priority:	Standard	Application Received:	05/15/2014

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 Physical Medicine and Rehabilitation 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 patient is a 37 year old female who was injured on 04/27/2008. The mechanism of injury is unknown. Prior medication history included Ultram, Ketoprofen, and tramadol. She has been treated conservatively with home exercise program and physical therapy. Progress report dated 04/29/2014 states the patient presented with low back pain and knee pain that radiates into her right buttock and hip. She noted the quality of the pain and sharp and throbbing. She rates it as a 5/10. The pain is constant in intensity. The pain is associated with arthralgia bilaterally knees. Joint stiffness of right knee joint. Objective findings on exam revealed an antalgic gait. There are no other findings present. Diagnoses are low back pain and knee pain. The recommendations are trazodone (insomnia), Ketoprofen and tramadol for pain. Prior utilization review dated 05/05/2014 by [REDACTED] states the request for Ketoprofen 75 Mg X2 Refills is denied as medical necessity has not been established; Trazadone 50 Mg, # 15 X2 Refills is denied as medical necessity has not been established; and Tramadol 50 Mg, # 30 X2 Refills is denied as medical necessity has not been established.

IMR ISSUES, DECISIONS AND RATIONALES

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

KETOPROFEN 75 MG X2 REFILLS: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs), Nonselective NSAIDs Ketoprofen Page(s): 67-68, 71-72.

Decision rationale: According to the California MTUS, NSAIDs are recommended as an option for short-term symptomatic relief. Given that medical record showed that the patient has back and knee pain, it is reasonable that the patient be provided with a nonsteroidal anti-inflammatory to provide symptomatic relief of mild to moderate pain. This request is supported by the referenced guidelines.

TRAZADONE 50 MG, # 15 X2 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tricyclic antidepressants Page(s): 15-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Insomnia; Insomnia Treatment.

Decision rationale: 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. The medical record did not demonstrate the evaluation. In addition, the guidelines recommend use of this medication only for short term periods. Prolonged use is not recommended or supported by the guidelines. It is also relevant that the medical records do not document the patient's attempts to establish and maintain appropriate sleep hygiene. Given the reasons above, the medical necessity of this medication has not been established.

TRAMADOL 50 MG, # 30 X2 REFILLS: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Opioids, specific drug list, Tramadol Page(s): 76-78, 93-94.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, continued opioid treatment requires documented pain and functional improvement and response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. In addition, the guidelines also note that opioids may be efficacious for short-term use, but the efficacy of long-term use is limited. Prolonged use of opioid leads to increased risk of dependence, comorbidity and mortality. However, weaning is advised to avoid withdrawal symptoms. This request is necessary for the treating physician to wean the patient in the next 2-3 months. Therefore, the medical necessity of opiate has been established. I am reversing the prior UR decision.