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| Case Number: | CM15-0109184 | | |
| Date Assigned: | 06/15/2015 | Date of Injury: | 07/29/2008 |
| Decision Date: | 07/14/2015 | UR Denial Date: | 05/09/2015 |
| Priority: | Standard | Application Received: | 06/05/2015 |

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: North Carolina

Certification(s)/Specialty: Family Practice

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 injured worker is a 42 year old male, who sustained an industrial injury on 7/29/08. He reported initial complaints of right knee injury. The injured worker was diagnosed as having right knee pain; history of tibial plateau fracture right knee; depression, not otherwise classified. Treatment to date has included status post right knee arthroscopic partial lateral meniscectomy, open reduction internal fixation tibial plateau fracture with bone graft (8/11/08); physical therapy; medications. Diagnostics included MRI right knee (5/31/13). Currently, the PR-2 notes dated 4/30/15 indicated the injured worker returns to this office for re-evaluation. The last he was in the office was 1/23/15. He continues to complain of right knee pain. His pain is described as aching and worse at the end of a workday. He rates his pain as 7-8/10 without pain medications and 3-4/10 with pain medication. The pain is aggravated by standing, walking and bending and is alleviated by medications. The injured worker is a status post right knee arthroscopic partial lateral meniscectomy, open reduction internal fixation tibial plateau fracture with bone graft (8/11/08) due to his industrial related injury. The provider documented a surgical consult dated 2/3/14 which recommended a debridement of the right knee but the injured worker was not in position to have the surgery at that time due to starting a new job. A new surgical consult was requested but has been denied. On physical examination of the right knee, the provider notes a healed surgical scar on the lateral aspect with tenderness over the lateral joint line. Range of motion is limited with extension 0 degrees, flexion 0 to 100 degrees, strength 5/5 for both lower extremities. The injured worker ambulates independently without any assistive devices with a slightly antalgic gait. MRI of the right knee dated 5/31/13 showed a healed lateral tibial plateau

fracture with mild articular surface irregularity, chronic contusion /tear of the lateral meniscus horn. No acute meniscal tear is identified. The provider treatment plan notes to continue with tramadol as this helps with pain and allows him to continue working. The provider is requested authorization of Ultram 50mg 100 tablets.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultram 50mg 100 tablets: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 76-84.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy (b) The lowest possible dose should be prescribed to improve pain and function (c) Office: 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. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4As for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4As" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion) (g) Continuing review of overall situation with regard to non-opioid means of pain control (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids: (a) If the patient has returned to work (b) If the patient has improved functioning and pain (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997)

(Wisconsin, 2004) (Warfield, 2004)The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. These criteria have been met and the request is medically necessary.