

<b>Case Number:</b>	CM15-0169383		
<b>Date Assigned:</b>	09/10/2015	<b>Date of Injury:</b>	03/04/2014
<b>Decision Date:</b>	10/08/2015	<b>UR Denial Date:</b>	08/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/28/2015

### 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 43 year old male who sustained an industrial injury on 03-04-2014. He reported injury to his neck, back and right lower extremity. Treatment to date has included medications, physical therapy, acupuncture, lumbar epidural steroid injection and trigger point injections. According to a pain management consultation dated 07-08-2015 an MRI of the lumbar spine performed on 05-16-2014 revealed multilevel disc disease including a 4.7 millimeter disc herniation with bilateral neural foraminal stenosis at L4-5. MRI of the cervical spine revealed abnormalities including a 2.8 millimeter disc protrusion with bilateral neural foraminal stenosis at C5-6. MRI of the right ankle revealed tenosynovitis involving the posterior tibial tendon, flexor digitorum longus, flexor hallucis longus, peroneus longus and peroneus brevis. According to a comprehensive pain management consultation dated 07-08-2015, the injured worker reported pain in his neck. Pain was rated 5 on a scale of 0-10. Low back pain was rated an 8 in intensity and radiated down to his right lower extremity. He could only stand for about 30 minutes at a time which continued to limit both his ability and activity intolerance. He experienced pain when he walked up or down stairs. Right ankle pain was aggravated by any type of weight bearing. Medication regimen by another provider included Anaprox, Ultram, Prilosec and Fexmid. Assessment included cervical herniated nucleus pulposus, lumbar herniated nucleus pulposus with bilateral lower extremities radiculopathy, right carpal tunnel syndrome and right ulnar neuropathy at the level of the elbow, right ankle internal derangement and medication-induced gastritis. The treatment plan included a series of two diagnostic transforaminal epidural steroid injections at L5-S1 bilaterally and four trigger point injections.

The injured worker was to follow up with his orthopedic spine surgeon following the epidural injection. According to a partially legible handwritten progress report dated 07-21-2015, the injured worker continued to report low back and right ankle pain. A lumbar epidural was scheduled. Ankle was painful on weight bearing. Posterior right ankle was tender. Diagnoses included sprain and strain of lumbosacral, neck sprain and strain and thoracic sprain and strain. The provider noted that the injured worker was getting an epidural in September and that the injured worker needed ankle injections. Prescriptions were given for Prilosec, Naprosyn and Fexmid. The injured worker was to remain off work until September 1, 2015. Documentation submitted for review shows long term use of opioids. Urine drug screens were not submitted for review. On 08-06-2015, Utilization Review non-certified Tramadol HCL ER 150 mg #30, noting that activities of daily living and aberrant drug taking behaviors were not addressed.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Tramadol HCL ER 150mg #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

**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 4 A's 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 "4 A's" (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 dairy 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. There is no documented significant improvement in VAS scores for significant periods of time. There are no objective measurements of improvement in function. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.