MAXIMUS Federal Services

Case Number:	CM15-0184431		
Date Assigned:	09/24/2015	Date of Injury:	07/05/2011
Decision Date:	11/19/2015	UR Denial Date:	09/14/2015
Priority:	Standard	Application Received:	09/18/2015

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: Colorado
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 48 year old female who sustained an industrial injury on July 05, 2011. A recent primary treating office visit dated October 02, 2015 reported subjective complaint of "lower backache." Pain rated 2/10 with medications and 3/10 without medications, but improved overall. Her activity level is noted to be increased. Current medication regimen consisted of: Tramadol, Zanaflex, Ativan, Cymbalta, and Wellbutrin. (Records indicate patient is taking medications as prescribed, but then also indicates that she admits to over-taking medications whenever her non-industrial pain flare up.) The following diagnoses were applied to the October 02, 2015 visit: other intervertebral disc degeneration, lumbar region, dorsalgia, unspecified, and mood disorder due to known physiological condition, unspecified. The plan of care includes Lumbar Medial Branch Block. MRI report dated November 20, 2014 showed: patient has facet arthropathy at L4-5 and physical examination showed positive facet loading on right side. A CURES report from September 04, 2014, April 03, 2015 and June 04, 2015 all with findings positive for Norco that is prescribed from another provider and she is noted taking it for "flare-ups of her non-industrial injury, foot." The records indicate that patient started Tramadol at August 6, 2015 as a trial because "patient has bloating issues with Percocet and Norco." (However, multiple notes indicate "trial Tramadol" in the plan) She is to continue Zanaflex at decreased dose for spasms and requesting a medial branch block injection. On September 04, 2015 a request was made for Tramadol 50mg #80 that was noncertified by Utilization Review on September 14, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol HCL 50 mg #60: 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, criteria for use, Opioids for chronic pain, Opioids, differentiation: dependence & addiction, Opioids, specific drug list.

Decision rationale: Tramadol is a synthetic opioid that exerts its effect on the central nervous system. The MTUS Guidelines establish criteria for use of opioids, including long-term use (6 months or more). When managing patients using long-term opioids, the following should be addressed: Re-assess the diagnosis and review previous treatments and whether or not they were helpful. When re-assessing, pain levels and improvement in function should be documented. Pain levels should be documented every visit. Function should be evaluated every 6 months using a validated clinical assessment tool. Adverse effects, including hyperalgesia, should also be addressed each visit. Patient's motivation and attitudes about pain / work / interpersonal relationships can be examined to determine if patient requires psychological evaluation as well. Aberrant / addictive behavior should be addressed if present. Do not decrease dose if effective. Medication for breakthrough pain may be helpful in limiting overall medication. Follow up evaluations are recommended every 1-6 months. To summarize the above, the 4A's of Drug Monitoring (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking Behaviors) have been established. 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) Several circumstances need to be considered when determining to discontinue opioids: 1) Verify patient has not had failure to improve because of inappropriate dosing or under-dosing of opioids. 2) Consider possible reasons for immediate discontinuation including diversion, prescription forgery, illicit drug use, suicide attempt, arrest related to opioids, and aggressive or threatening behavior in clinic. Weaning from the medication over 30 day period, under direct medical supervision, is recommended unless a reason for immediate discontinuation exists. If a medication contract is in place, some physicians will allow one infraction without immediate discontinuation, but the contract and clinic policy should be reviewed with patient and consequences of further violations made clear to patient. 3) Consider discontinuation if there has been no improvement in overall function, or a decrease in function. 4) Patient has evidence of unacceptable side effects. 5) Patient's pain has resolved. 6) Patient exhibits "serious non-adherence" or misuse. Per the Guidelines, Chelminski defines "serious substance misuse" as meeting any of the following criteria: (a) cocaine or amphetamines on urine toxicology screen (positive cannabinoid was not considered serious substance abuse); (b) procurement of opioids from more than one provider on a regular basis; (c) diversion of opioids; (d) urine toxicology screen negative for prescribed drugs on at least two occasions (an indicator of possible diversion); & (e) urine toxicology screen positive on at least two occasions for opioids not routinely prescribed. (Chelminski, 2005) 7) Patient requests discontinuing opioids. 8) Consider verifying

that patient is in consultation with physician specializing in addiction to consider detoxification if patient continues to violate the medication contract or shows other signs of abuse / addiction. 9) Document the basis for decision to discontinue opioids. Likewise, when making the decision to continue opioids long term, consider the following: Has patient returned to work? Has patient had improved function and decreased pain with the opioids? For the patient of concern, the records do indicate that the 4 A's are discussed at every visit with primary provider, but inconsistent urine drug screens are not actually addressed and the patient's continued overuse of medications is not curtailed. Patient has multiple clinic notes in 2015 that document patient "overtaking" medications because of comorbid, non-industrial pain, and CURES report that shows fills of Norco from another provider, which patient did not discuss with primary provider until after the fact. On 2 separate urine drug screens, patient was negative for another controlled substance (Lorazepam) and positive for Hydrocodone which patient was not to be taking at those times. Based on the records, patient is actually exhibiting serious misuse of controlled substances and is at high for continued aberrant behaviors, so the request for Tramadol is not medically indicated.