

Case Number:	CM14-0156704		
Date Assigned:	09/26/2014	Date of Injury:	07/17/2001
Decision Date:	10/27/2014	UR Denial Date:	09/04/2014
Priority:	Standard	Application Received:	09/24/2014

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, has a subspecialty in Interventional Spine 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 74 year old male with an injury date of 07/17/01. Per the 08/12/14 progress report by [REDACTED] supervised by [REDACTED], the patient presents with lower back pain with occasional radiation to the lower extremities in addition to left knee pain exacerbated with prolonged weight bearing. Examination of the left knee reveals tenderness along the medial joint line as well as the patella facets. There is subpatellar crepitation with range of motion and pain with deep flexion. Examination of the lumbar spine shows tenderness about the lower lumbar paravertebral musculature. The patient's diagnoses include Left knee medial and patellofemoral arthrosis, moderate, Lumbar spine stenosis and Lumbar radiculopathy. Current medications are listed as Voltaren, Ultram, and Ambien. The utilization review being challenged is dated 09/04/14. Treatment reports were provided from 01/14/14 to 08/12/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultram 50mg #60 with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going management.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Long Term opioid use, Criteria for Opioid Use Page(s): 88-89, 78.

Decision rationale: The patient presents with lower back pain radiating to the lower extremities in addition to left knee pain. The treater requests for Ultram (Tramadol an opioid analgesic) 50 mg #60 with 3 refills. The 09/04/14 utilization review modified this request to 0 refills. It is not known exactly how long the patient has been taking this medication. It is listed on all treatment reports provided beginning 01/14/14. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. The treater states adjunct medications help the patient's functional improvement. However, the reports show no discussion of pain assessment or outcome measures as required above. No specific ADLs are mentioned to show a significant change of use with medication. Furthermore, opiate management issues are not discussed and urine toxicology reports are not discussed or provided. In this case, there is not sufficient documentation as required by MTUS guidelines above for long term opioid use. Therefore, recommendation is for denial.

Ambien 10mg #15 with 0 refills: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Insomnia, Insomnia Treatment

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG Pain (Chronic) Chapter Zolpidem (Ambien) Topic

Decision rationale: The patient presents with lower back pain radiating to the lower extremities in addition to left knee pain. The treater requests for Ambien 10 mg #15. MTUS and ACOEM Guidelines do not address Ambien; however, ODG Guidelines state that Ambien) is indicated for short-term treatment of insomnia with difficulty of sleep onset 7 to 10 days. The treater states on 08/12/14 that the patient's function improves with medications. The use and efficacy of this medication specifically is not discussed. In this case, the records provided show the patient has been using this medication since 01/14/14. Long-term use is not recommended by ODG; therefore, recommendation is for denial.