

<b>Case Number:</b>	CM15-0171385		
<b>Date Assigned:</b>	09/11/2015	<b>Date of Injury:</b>	04/05/2013
<b>Decision Date:</b>	10/09/2015	<b>UR Denial Date:</b>	08/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/31/2015

### 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 49-year-old male, who sustained an industrial injury on 4-5-2013. The injured worker was diagnosed as having sacroiliac ligament sprain and strain, lumbar disc displacement without myelopathy, and supra glenoid labrum lesion. The request for authorization is for Tramadol HCL-APAP 37.5mg #50. The UR dated 8-11-2015: modified certification of Tramadol HCL-APAP 37.5mg #28; and certified Gabapentin 600mg #60. The records indicate he has been utilizing Tramadol HCL-Acetaminophen since at least August 2014, possibly longer. On 7-2-2015, he reported persistent low back and thigh pain. The subjective information indicated that he had "significant" pain relief of 50% with the use of Tramadol and Gabapentin. Physical findings were noted as flexion of the lumbar spine at 60 degrees and limited, with full strength of the bilateral lower extremities and a negative straight leg raise bilaterally. The examination also revealed that the hip did not "illicit exquisite pain" and a slight positive Faber exam on the right hip while the Faber exam was negative on the left hip, and tenderness in the piriformis area. On 7-31-2015, he reported low back and right hip and right upper thigh pain. He also reported having "significant" pain relief with the use of Tramadol and Gabapentin, which is noted to give approximately 50% pain relief and increased tolerance for standing and walking. Physical findings revealed lumbar flexion to be limited, bilateral lower extremities at full strength, and a negative straight leg raise test. There is also tenderness upon palpation of the right hip, and a positive Faber on the right hip, and tenderness in the right piriformis area with a positive facet loading on the right. Current medications are: Gabapentin, Tramadol HCL-APAP 37.5mg-325mg take one tablet every 8 hours, Salonpas patch, Tramadol-

APAP (prescribed by another physician), and Zolpidem (prescribed by another physician). The work status is reported as not permanent and stationary. On 8-11-2015, there is no subjective information. Current medications are noted as: Gabapentin, Tramadol HCL-APAP 37.5mg-325mg take one tablet every 8 hours, Salonpas patch, Tramadol-APAP (prescribed by another physician), and Zolpidem (prescribed by another physician). The provider made a notation regarding a peer-to-peer review call as being unable to complete. The treatment and diagnostic testing to date has included magnetic resonance imaging of the lumbar spine (5-1-2013), magnetic resonance imaging of the right hip (5-1-2013), medications, and approximately 12 physical therapy sessions, and AME (7-7-2015).

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

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

**Tramadol HCL/APAP (hydrochloride/acetaminophen) 37.5mg, #50:** Overturned

**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 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 are met in the provided medical records for review and thus the request is medically necessary.