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| <b>Case Number:</b>   | CM15-0171866 |                              |            |
| <b>Date Assigned:</b> | 09/14/2015   | <b>Date of Injury:</b>       | 10/23/2013 |
| <b>Decision Date:</b> | 10/13/2015   | <b>UR Denial Date:</b>       | 08/24/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/01/2015 |

### 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:

This is a 53-year-old female worker who was injured on 10-23-2013. The medical records reviewed indicated the injured worker was treated for sprain, unspecified site of knee and leg; meniscus tear; and chronic pain syndrome. The progress notes (8-6-15) indicated the IW had left knee pain rated 7 out of 10. She reported her least pain since last exam was 7 out of 10 and average pain was 8 out of 10. Her pain with medications was 7 out of 10 and without medications was 10 out of 10. Her pain medication was effective for 5 hours. Medications were Tramadol (since at least 6-4-2015), Pamelor and Excedrin. The IW was on modified work status. On physical examination (7-6-15 and 8-6-15 records) range of motion of the left knee was 0 to 95 degrees and painful with tenderness to palpation. There was patellofemoral crepitus and 4-weakness in the left quadriceps. There was also "clicking" at the patellofemoral articulation. The urine drug screen on 7-14-15 was inconsistent: it was negative for Tramadol. The provider noted the IW preferred to "minimize oral medication use; however pain continues to be bothersome and interferes with activity". Per the physical therapy report (6-16-15) treatments included left knee arthroscopy 11-2014 and left knee manipulation 3-20-15 and 23 physical therapy visits. The treatment plan included decreasing Tramadol; discontinuing Pamelor per the IW's request; and trial Vistaril for pain related insomnia and anxiety. A Request for Authorization dated 8-12-15 was received for Vistaril 25mg, #30 one at bedtime and Tramadol 50mg, #28 one daily. The Utilization Review on 8-24-15 non-certified the request for Vistaril 25mg, #30 one at bedtime, as the clinical documentation did not support the need for the medication and Tramadol 50mg, #28

one daily was non-certified because chronic opioid use was not supported in the current clinical setting.

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

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

**Tramadol 50mg #28 one qd:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 nonopioid 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 documentation of review and the request is medically necessary.

**Vistaril 25mg #30 one at HS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) insomnia.

**Decision rationale:** The California MTUS and the ACOEM do not specifically address this medication. Per the official disability guidelines recommend pharmacological agents for insomnia only is used after careful evaluation of potential causes of sleep disturbance. Primary insomnia is usually addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. Pharmacological treatment consists of four main categories: Benzodiazepines, Non-benzodiazepines, Melatonin and melatonin receptor agonists and over the counter medications. Sedating antidepressants have also been used to treat insomnia however there is less evidence to support their use for insomnia, but they may be an option in patients with coexisting depression. The patient does not have the diagnosis of primary insomnia or depression. There is no provided clinical documentation of failure of sleep hygiene measures/counseling. Therefore the request is not medically necessary.