

Case Number:	CM15-0178347		
Date Assigned:	09/18/2015	Date of Injury:	06/03/2014
Decision Date:	10/22/2015	UR Denial Date:	08/16/2015
Priority:	Standard	Application Received:	09/10/2015

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 56-year-old female worker who was injured on 6-3-2014. The medical records indicated the injured worker (IW) was treated for back pain, lumbar. According to the progress notes (7-30-15 and 8-13-15), the IW reported moderate low back pain with muscle spasms and pain radiating to both thighs and legs, with weakness. Home exercise and Ibuprofen were minimally effective. Medications were Cyclobenzaprine 10mg, Tramadol 50mg (since at least 4-20-15), which improved sleep by greater than 20% and Nabumetone 750mg, which did not change the symptoms. A previous Toradol injection was effective. The IW was off work, as the employer was unable to accommodate her work status. The physical examination (6-11-15 and 8-13-15) was unchanged; tenderness was noted in the muscles of the lumbar spine and over the L4 and L5 spinous processes and the sacrum. There was bilateral pain with straight leg raise in a supine position, but the response was inconsistent with seated straight leg raise. There was also superficial or skin tenderness to light palpation, non-anatomic tenderness, pain with axial cervical loading, non-dermatomal sensory change, regional muscle weakness and inconsistent painful response to stimulus. Ranges of motion of the lumbar spine were decreased due to pain. Numbness and tingling to light touch was present in the bilateral posterior calves. Treatments have included lumbar surgery and physical therapy, which was not effective after two of six sessions. An MRI of the lumbar spine on 4-30-15 showed loss of lordosis, no significant disc space narrowing or facet hypertrophy; and minimal osteophytic bone spurring. A Request for Authorization was received for a retrospective prescription for Tramadol HCl 50mg, #30 for date

of service 7-30-15. The Utilization Review on 8-16-15 non-certified the request for a retrospective prescription for Tramadol HCl 50mg, #30 for date of service 7-30-15 because the CA MTUS Chronic Pain Medical Treatment Guidelines were not met.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective 1 prescription of Tramadol HCL 50mg #30 (DOS 07/30/2015): 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 nonadherent) 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. There is no documented significant decrease in objective pain measures such as VAS scores for significant periods of time. There are no objective measures of improvement of function or how the medication improves activities. The work status is not mentioned. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.