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| Case Number: | CM13-0023316 | | |
| Date Assigned: | 11/15/2013 | Date of Injury: | 04/06/2005 |
| Decision Date: | 05/13/2014 | UR Denial Date: | 08/28/2013 |
| Priority: | Standard | Application Received: | 09/12/2013 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Sports Medicine, and is licensed to practice in Texas. 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 Physician 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 injured worker is a 58-year-old female who reported an injury on 04/06/2005. The mechanism of injury is not provided. Current diagnoses include displacement of lumbar intervertebral disc without myelopathy, spinal stenosis, and thoracic or lumbosacral neuritis or radiculitis. The injured worker was evaluated on 10/02/2013. The injured worker reported ongoing lower back pain with radiation to the left lower extremity. Prior conservative treatment was not mentioned. Current medications include Ultram 50 mg and Ultram ER 200 mg. Physical examination revealed tenderness to palpation, painful and restricted lumbar range of motion, 5/5 motor strength, and diminished sensation with positive straight leg raising. Treatment recommendations included continuation of current medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHARMACY PURCHASE OF ULTRAM 50 MG NUMBER FORTY-FIVE (#45) WITH ONE (1) REFILL: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY DURATION GUIDELINES, TREATMENT IN WORKERS COMPENSATION, 2013 WEB-BASED EDITION.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 74-82.

Decision rationale: The California MTUS Guidelines indicate that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. According to the documentation submitted, the injured worker has utilized this medication since at least 01/2013. There is no documentation of objective functional improvement. Therefore, ongoing use cannot be determined as medically appropriate. There is also no frequency listed in the current request. Based on the clinical information received, the request for Ultram 50mg number forty five (#45) with one (1) refill is non-certified.

PHARMACY PURCHASE OF ULTRAM ER 200 MG NUMBER THIRTY (#30) WITH ONE (1) REFILL: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY DURATION GUIDELINES, TREATMENT IN WORKERS COMPENSATION, 2013 WEB-BASED EDITION.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 74-82.

Decision rationale: The California MTUS Guidelines indicate that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. According to the documentation submitted, the injured worker has utilized this medication since at least 01/2013. There is no documentation of objective functional improvement. Therefore, ongoing use cannot be determined as medically appropriate. There is also no frequency listed in the current request. Based on the clinical information received, the request for Ultram ER 200mg number thirty (#30) with one (1) refill is non-certified.

ROUTINE DRUG SCREEN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43, 77 AND 89. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), CHRONIC PAIN CHAPTER, URINE DRUG TESTING.

Decision rationale: The California MTUS Guidelines indicate that drug testing is recommended as an option, using a urine drug screen to assess for the use or presence of illegal drugs. The Official Disability Guidelines indicate that the frequency of urine drug testing should be based on documented evidence of risk stratification. According to the documentation submitted, the date of injury is greater than 8 years ago, and there is no indication of noncompliance or misuse

of medication. There is no indication that this injured worker falls under a high-risk category that would require frequent monitoring. Additionally, the injured worker underwent a urine drug screen on 01/15/2013, which indicated consistent results. The medical necessity for ongoing repeat testing has not been established. As such, the request for routine drug screen is non-certified.