

Case Number:	CM13-0041572		
Date Assigned:	12/20/2013	Date of Injury:	07/03/2007
Decision Date:	02/21/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	10/29/2013

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 Pain Management has a subspecialty in Disability Evaluation 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 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 patient is a 58-year-old male who was injured on 7/3/2007. The patient states that the injury occurred while he was lifting irrigation pipes all day, which he estimated weighted 80-90 lb. He claims that after his break he picked up an irrigation pipe and experienced central low back pain. The patient reported the incident to his employer and for the rest of the day his supervisor helped him carry the irrigation pipes. The following day (on his own) the patient went to [REDACTED] and was diagnosed with kidney problems. He was subsequently told her had a lower back problems and was sent to his company doctor. Treatment included medications, physical therapy, and injections. The patient states that the treatment was of no benefit and he was referred to a neurosurgeon. The patient underwent surgery in September of 2008 and indicated that he initially felt better after surgery but when sent to physical therapy in February 2009 his symptoms progressively got worse. Therapy was stopped and a back injection was administered however that did not help. Presently the patient states he feels worse since surgery because of problems that arose in physical therapy with increased back pain. Pain is stated primarily to be in the low back and extends to the left leg with pain and numbness in all toes. In the most recent medical report dated September 20, 2013, the treating physician wrote The patient reports the same pain intensity and no change in distribution. Patient denies any changes in medications, recent illness/injury, hospitalizations, or diagnostic studies taken since last visit. His low back pain and leg complaints continue to worsen (numbness, cramping, and weakness). His AOL's are affected as well. He reports increased pain intensity but change in distribution. Current Meds: TRAMADOL HCL 150 MG XR24H-CAP (TRAMADOL HCL) one-two p.o. Qam pain (as recommended by G. I. Physician) AMBIEN 5 MG TABS (ZOLPIDEM TARTRATE) one-two P.O. QHS prn sleep (uses onl

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol HCL 150mg, #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Weaning of Medications-Opioids Page(s): 124.

Decision rationale: CA-MTUS (Effective July 18, 2009) Chronic Pain Medical Treatment Guidelines (pages 75, 80 and 84), Tramadol (Ultram)- classified as a small class of synthetic opioids, with opioid activity and a mechanism of action that inhibits the reuptake of serotonin and norepinephrine as a Central acting analgesics. This class of synthetic opioids have been reported to be effective in managing neuropathic pain, with side effects similar to traditional opioids. "Opioids efficacy is limited to short term pain relief, and long term efficacy is unclear". Failure to respond to a time-limited course of opioids has led to suggestion of reassessment and consideration of alternative therapy. Weaning of Medications Recommended as indicated below. Opioids: For opioids a slow taper is recommended. The longer the patient has taken opioids, the more difficult they are to taper. The process is more complicated with medical comorbidity, older age, female gender, and the use of multiple agents. Gradual weaning is recommended for long-term opioid users because opioids cannot be abruptly discontinued without probable risk of withdrawal symptoms. (Benzon, 2005). In the medical report dated September 20, 2013, the treating physician noted: "The patient was strongly advised to taper the medications as much as possible, and to utilize the lowest effective dose to maintain function. Also, I strongly advised against Alcohol use while using medications, and to avoid concurrent use with any other medications. The patient was strongly encouraged to keep all Medical Providers informed of current medications. Therefore the request for Tramadol HCL 150mg, #60 is medically necessary for weaning purposes."

Urine toxicology screening: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Screening Page(s): 43.

Decision rationale: According to MTUS (2009) page 43, urine drug screening is recommended as an option to assess for the use or the presence of illegal drugs. Also page 85 of MTUS states "urine drug screening is also used in Chelminski multi-disciplinary pain management program criteria: (Chelminski, 2005) Criteria used to define serious substance misuse in a multi-disciplinary pain management program: (a) cocaine or amphetamines on urine toxicology screen (positive cannabinoid was not considered serious substance abuse); (b) procurement of opioids from more than one provider on a regular basis; (c) diversion of opioids; (d) urine toxicology

screen negative for prescribed drugs on at least two occasions (an indicator of possible diversion); & (e) urine toxicology screen positive on at least two occasions for opioids not routinely prescribed". Since the patient was started on opioid weaning program, the request for a Urine toxicology screening is not medically necessary.