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| Case Number: | CM13-0053485 | | |
| Date Assigned: | 12/30/2013 | Date of Injury: | 01/10/2005 |
| Decision Date: | 03/20/2014 | UR Denial Date: | 10/31/2013 |
| Priority: | Standard | Application Received: | 11/18/2013 |

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 and Rehabilitation 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 physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records: The patient is a 40-year-old male who reported an injury on 01/10/2005 due to a laceration on the right hand. The patient ultimately underwent first and second extensor tendon laceration repair. The patient developed chronic pain which was managed with medications to include Ultram, naproxen, and Tramadol. Previous treatments included hot and cold compression garments, TENS unit, and immobilization with a brace. The patient's most recent clinical evaluation dated 10/22/2013 documented that the patient had tenderness along the first and second extensor tendon with some numbness and tingling that was exacerbated by repetitive movements. It was noted that the patient's pain was rated at a 6/10 to 7/10 without medications and reduced to a 3/10 to 4/10 with medications. The patient's treatment plan included continuation of medications for pain control to assist the patient in performing normal job duties and chores around the house.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol ER 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Section Page(s): 78.

Decision rationale: The requested Tramadol ER 150 mg #30 is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends opioids in the management of a patient's chronic pain be supported by documentation of functional benefit, a quantitative assessment of pain relief, managed side effects, and evidence that the patient is monitored for aberrant behavior. The clinical documentation submitted for review does indicate that the patient has significant pain relief from the patient's medication schedule. Clinical documentation does indicate that the patient started taking this medication in 05/2013. However, there is no documentation that the patient is monitored for compliance to the prescribed medication schedule. Additionally, the request as it is written does not contain a frequency that this medication should be taken. Therefore, appropriateness and the need for continued use cannot be determined. As such, the request of Tramadol ER 150 mg #30 is not medically necessary or appropriate.