

Case Number:	CM13-0064047		
Date Assigned:	01/03/2014	Date of Injury:	04/26/2013
Decision Date:	05/16/2014	UR Denial Date:	12/03/2013
Priority:	Standard	Application Received:	12/11/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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 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/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 57 year old male who was injured on 06/10/2013 while he lifted a steel platform walker that weighed approximately 80 pounds from a truck. The patient lowered the motor steel walker halfway down from the truck; he felt severe painful pulling sensation to his neck, right shoulder and lower back. Prior treatment history has included physical therapy. PR2 dated 11/18/2013 is illegible. Orthopedic consultation dated 06/10/2013 stated that based on the patient's history and the mechanism of injury and type of work he did, the clinical symptoms do correlate. The patient does not have any industrial or nonindustrial pathology or disability that has contributed to this. There is a reasonable medical certainty of an AOE/COE. This would be in regard to his cervical spine, thoracic spine, lumbosacral spine, right upper extremity and right lower extremity. Primary treating physician's visit notes dated 06/06/2013 documented the patient to have complaints of neck pain with intermittent aching and persistent symptoms. The patient noted continued numbness to the right hand without any associated weakness. He reported low back pain with intermittent aching pain and persistent symptoms. He had right shoulder pain with intermittent aching pain and persistent symptoms. There was no distal weakness or any symptoms of infection or tumor. Objective findings on exam revealed continued tenderness noted to the right paracervical and right trapezius with increased tone. Cervical range of motion revealed flexion to 1 inch from chest wall; extension to 30; lateral flexion to 30 bilaterally; rotation to 40 bilaterally. Motor exam revealed weakness on the right and left within normal limits; Reflexes were 2+ bilaterally. His sensory exam was within normal limits. The lumbosacral exam revealed a normal gait. There was tenderness to the right peri-lumbosacral area, without masses. Range of motion revealed forward extension to 20; bend to 20 bilaterally; rotation to 30 bilaterally. Straight leg raise, sitting was negative. DRTs were 2+/4. The right shoulder exam revealed continued tenderness to the posterior glenohumeral joint

without any AC joint tenderness. Range of motion of the right shoulder revealed forward flexion to 135; extension to 45; abduction to 90; adduction to 20; IR to 45; ER to 70; and abduction against resistance was mildly reduced secondary to pain. Impingement signs were negative as well as drop tests. There was decreased motor secondary to pain. The patient was diagnosed with lumbosacral strain, right shoulder strain and cervical strain. From 06/16/2013 to 11/18/2013, there are no progress notes provided for review. Previous UR approved weaning regimen for this patient.

IMR ISSUES, DECISIONS AND RATIONALES

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

ULTRAM 50MG #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids/Opioids For Chronic Pain, Weaning Of Medications Page(s): 74, 75, 80, 124.

Decision rationale: The Expert Reviewer's decision rationale: According to the CA MTUS Guidelines, Tramadol (Ultram®) is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic, it is indicated for moderate to severe pain. The CA MTUS Guidelines indicate "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 11/18/2013 PR-2 is illegible, and there are no reports from 06/16/2013 to 11/18/2013. The guidelines state opioids may be continued: (a) if the patient has returned to work and (b) if the patient has improved functioning and pain. The medical records have not demonstrated the requirements for continued opioid therapy have been met. Recommendation has previously been made for weaning. Chronic use of opioids is not generally supported by the medical literature. Opioids are considered a second-line treatment for several reasons: (1) head-to-head comparisons have found that opioids produce more side effects than TCAs and gabapentin; (2) long-term safety has not been systematically studied; (3) long term use may result in immunological and endocrine problems (including hypogonadism); (4) treatment may be associated with hyperalgesia; & (5) opioid use is associated with misuse/abuse. The medical necessity of Ultram has not been established. Per the guidelines, gradual weaning is recommended for long-term opioid users because opioids cannot be abruptly discontinued without probable risk of withdrawal symptoms.