

<b>Case Number:</b>	CM14-0007753		
<b>Date Assigned:</b>	02/07/2014	<b>Date of Injury:</b>	10/14/2011
<b>Decision Date:</b>	07/16/2014	<b>UR Denial Date:</b>	01/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2014

### 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 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 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 injured worker is a 57 year old male injured on 10/14/11 due to an undisclosed mechanism of injury. Current diagnoses include cervical discopathy, lumbar discopathy/segmental instability, status post right shoulder replacement on 08/16/13, bilateral carpal tunnel syndrome/double crush syndrome, and bilateral plantar fasciitis. Clinical note dated 10/08/13 indicates the injured worker presents with complaints of persistent pain in the neck aggravated by repetitive motions in addition to right shoulder pain with significant range of motion residual weakness. The documentation indicates symptomatology in the injured worker's bilateral hands/wrists, lumbar spine and bilateral feet remains essentially unchanged. Treatment plan includes aggressive physical therapy/range of motion for the right shoulder, per the operating surgeon, and Tramadol ER with appropriate medication precautions. The initial request for Tramadol ER 150 mg #90 was not medically necessary on 01/02/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TRAMADOL ER 150 MG #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, OPIOIDS - TRAMADOL (ULTRAM) Page(s): 113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 77.

**Decision rationale:** Patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. In addition, no recent opioid risk assessments regarding possible dependence or diversion were available for review. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics as well as establish the efficacy of narcotics, the medical necessity of tramadol ER 150 MG #90 cannot be established at this time.