MAXIMUS Federal Services

| Case Number: | CM14-0019679 | | |
|---|---|---|---|
| Date Assigned: | 04/28/2014 | Date of Injury: | 08/11/2003 |
| Decision Date: | 07/08/2014 | UR Denial Date: | 01/24/2014 |
| Priority: | Standard | Application Received: | 02/18/2014 |

## 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 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 injured worker is a 70 year old male who reported an injury on 08/11/2003 secondary to a fall. The clinical note dated 10/28/2013 reported the injured worker complained of severe pain in the lower back, pain in his knee and pain in his wrist. The physical examination revealed tenderness of the lumbosacral junction with spasms noted. There was a positive Tinel's sign and a positive Phalen's and reverse Phalen's sign. The diagnoses included failed total knee replacement arthroplasty, carpal tunnel syndrome, lumbar spinal stenosis and cardiac arrhythmia. His treatment included a recommendation for cardiac evaluation and medications to include Ambien, Norco, and Ultram.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**TRAMADOL HCL CAP 150MG, #60 WITH 1 REFILL:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80-81.

**Decision rationale:** The injured worker has a history of knee pain, bilateral wrist pain and low back pain. The CA MTUS Guidelines states opioids appear to be efficacious but limited for

short-term pain relief, and long term efficacy is unclear (>16 weeks) but also appears limited. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines note a pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The clinical information, provided for review, noted the injured worker had severe knee pain and bilateral wrist pain with treatment to include medication refills. However, the requesting physician did not include a complete assessment of the injured worker's pain to include current pain or the relief of pain or quantifiable objective functional improvement with the medication. In addition, there is a lack of documentation the physician addressed signs or symptoms of aberrant behavior and side effects of this medication. Therefore, the request for Tramadol HCL Cap 150mg, #60 with 1 refill is not medically necessary and appropriate.