

Case Number:	CM14-0110195		
Date Assigned:	09/24/2014	Date of Injury:	02/09/2008
Decision Date:	10/24/2014	UR Denial Date:	06/17/2014
Priority:	Standard	Application Received:	07/14/2014

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 Internal Medicine, has a subspecialty in Nephrology 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:

This case involves a 67-year-old male with a 2/9/08 date of injury. A specific mechanism of injury was not described. According to a progress report dated 5/30/14, the patient complained of continued moderate to severe lower back pain with radicular symptoms down the left buttock region. His right shoulder has substantially improved with minimal complaints of pain. Objective findings include positive tenderness and muscle spasms to palpation in paralumbar musculature, motor testing 5/5 to all muscle groups of lower extremities, painful range of motion of lumbar spine, and positive AC joint tenderness. Diagnostic impression include chronic recalcitrant low back pain, herniated disc lumbar spine, radiculitis left lower extremity, and right shoulder impingement syndrome. Treatment to date includes medication management, activity modification. A UR decision dated 6/17/14, denied the request for Tramadol ER. Based on the medical documentation provided, it is required to provide a visual analog scale before and while taking pain regimens such as Tramadol to help determine if the medication is working.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Tramadol ER 150mg # 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Tramadol (Ultram).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. However, in the reports reviewed, there is no documentation of significant pain reduction or improved activities of daily living. Guidelines do not support the continued use of opioid medications without documentation of functional improvement. In addition, there is no documentation of lack of aberrant behavior or adverse side effects, an opioid pain contract, urine drug screen, or CURES monitoring. Furthermore, there is no documentation of the date of service being requested for this retrospective request. Therefore, the request for Retro Tramadol ER 150mg # 60 was not medically necessary.