

Case Number:	CM14-0110784		
Date Assigned:	09/16/2014	Date of Injury:	04/19/2003
Decision Date:	10/15/2014	UR Denial Date:	07/14/2014
Priority:	Standard	Application Received:	07/16/2014

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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 53-year-old male who reported an injury on 04/19/2003 due to an unknown mechanism. Diagnosis was right shoulder impingement syndrome. Physical examination 05/12/2014 revealed that the injured worker was having pain with reaching, pulling, and pushing. There were complaints of difficulty sleeping. He stated that activities of daily living were difficult because of the shoulder pain. Examination revealed tenderness over the anterolateral aspect of the right shoulder. Impingement sign was positive. There was weakness to the right shoulder abduction. Drop arm test was negative. Passive motion of the right shoulder was to 140 degrees of flexion, 140 degrees abduction, 20 degrees of internal rotation, 80 degrees of external rotation, 30 degrees of extension, and 20 degrees adduction. Medications were not reported. Treatment plan was for a right subacromial space to be injected with steroid, lidocaine, and Marcaine. The rationale and Request for Authorization were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 81, 84.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol, Ongoing Management Page(s): 82, 93, 94, 113, 78.

Decision rationale: The decision for tramadol 50 mg quantity 180 is not medically necessary. The California Medical Treatment Utilization Schedule states central analgesic drugs such as tramadol (Ultram) are reported to be effective in managing neuropathic pain and it is not recommended as a firstline oral analgesic. The medical guidelines recommend that there should be documentation of the "4 A's" for ongoing monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The 4 A's for ongoing monitoring were not reported. The request does not indicate a frequency for the medication. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, this request is not medically necessary.