

<b>Case Number:</b>	CM14-0111745		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	05/03/2001
<b>Decision Date:</b>	09/09/2014	<b>UR Denial Date:</b>	06/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/17/2014

### 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 and is licensed to practice in Illinois. 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 55-year-old female who reported an injury on 05/03/2001. The mechanism of injury was not stated. The current diagnoses include chronic pain syndrome, lumbar radiculitis, lumbar degenerative disc disease, low back pain, cervical degenerative disc disease, cervical radiculopathy, neck pain, dysthymic disorder, trigger middle finger of the right hand, carpal tunnel syndrome, rectal bleeding, and overactive bladder. The injured worker was evaluated on 05/28/2014 with complaints of persistent pain and incontinence. The current medication regimen includes Tramadol ER 150 mg, Gabapentin 300 mg, Norco 5/325 mg, Prilosec 20 mg, Zolof 25 mg to 50 mg, Lisinopril 20 mg, and Colace 100 mg. The physical examination revealed limited strength in the bilateral lower extremities, reduced sensation in the bilateral lower extremities, 1+ deep tendon reflexes, sacroiliac joint tenderness bilaterally, tenderness over the paraspinal muscles, increased pain with flexion and extension, decreased range of motion, and positive straight leg raising bilaterally. Treatment recommendations included continuation of the current medication regimen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One prescription of Ultram 150mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the injured worker has continuously utilized this medication since 03/2013. There is no documentation of objective functional improvement. There is also no frequency listed in the current request. As such, Ultram 150mg #30 is not medically necessary.