

Case Number:	CM14-0021734		
Date Assigned:	02/24/2014	Date of Injury:	09/04/2008
Decision Date:	06/26/2014	UR Denial Date:	12/10/2013
Priority:	Standard	Application Received:	01/08/2014

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 Family Practice, has a subspecialty in Preventative Medicine 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 claimant is a 59-year-old female who sustained a work injury on 4/22/08 involving the wrists, legs and shoulders. She had a diagnosis of a SLAP tear, carpal tunnel syndrome and myofascial pain. An exam note on 10/18/13 indicated she had 9/10 pain. Prior acupuncture and therapy had provided some improvement. Physical findings were notable for decreased range of motion in the upper extremities and numbness in the left upper extremity. The treating physician had continued prior orders including home exercise program, Ultram (tramadol), Naproxen and LidoPro. A follow-up was recommended for trigger point injections and ultrasound therapy. On 12/12/13 and 1/15/14, the pain was essentially unchanged and exam findings were unchanged and the same medications were continued along with a request for myofascial release.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRAMADOL 50MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TRAMADOL (ULTRAM).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TRAMADOL Page(s): 93-94.

Decision rationale: According to the MTUS guidelines, Opioid analgesics and Tramadol have been suggested as a second-line treatment (alone or in combination with first-line drugs). A recent consensus guideline stated that opioids could be considered first-line therapy for the following circumstances: (1) prompt pain relief while titrating a first-line drug; (2) treatment of episodic exacerbations of severe pain; [&] (3) treatment of neuropathic cancer pain. Tramadol is a synthetic opioid affecting the central nervous system. The immediate release formulation is recommended at a dose of 50 to 100mg by mouth (PO) every 4 to 6 hours (not to exceed 400mg/day). This dose is recommended after titrating patients up from 100mg/day, with dosing being increased every 3 days as tolerated. For patients in need of immediate pain relief, which outweighs the risk of non-tolerability the initial starting dose, may be 50mg to 100mg every 4 to 6 hours (max 400mg/day). Ultram ER®: Patient currently not on immediate release tramadol should be started at a dose of 100mg once daily. The dose should be titrated upwards by 100mg increments if needed (Max dose 300mg/day). Patients currently on immediate release Tramadol calculate the 24-hour dose of immediate release (IR) and initiate a total daily dose of extended release (ER) rounded to the next lowest 100mg increment (Max dose 300mg/day). Treatment of chronic lumbar root pain: A limitation of current studies is that there are virtually no repeated dose analgesic trials for neuropathy secondary to lumbar radiculopathy. A recent study that addressed this problem found that chronic lumbar radicular pain did not respond to either a tricyclic antidepressant or opioid in doses that have been effective for painful diabetic neuropathy or postherpetic neuralgia. Morphine was the least effective treatment (reducing leg and back pain by 1-7% compared to placebo). Sample size and dropout rate was a limitation. (Khoromi, 2007). Tramadol is not recommended as a first-line therapy for osteoarthritis. Short-term use is recommended on a trial basis for short-term use after there has been evidence of failure of first-line non-pharmacologic and medication options (such as acetaminophen or NSAIDs) and when there is evidence of moderate to severe pain. Tramadol is also recommended for a trial if there is evidence of contraindications for use of first-line medications. Weak opioids should be considered at initiation of treatment with this class of drugs (such as Tramadol, Tramadol/acetaminophen, hydrocodone and codeine), and stronger opioids are only recommended for treatment of severe pain under exceptional circumstances (oxymorphone, oxycodone, hydromorphone, fentanyl, morphine sulfate). Benefits of opioids are limited by frequent side effects (including nausea, constipation, dizziness, somnolence and vomiting). (Stitik, 2006) (Avouac, 2007) (Zhang, 2008). In this case, Tramadol had been used for several months without improvement in subjective or objective findings. Failure of first line medications was not mentioned. Continued use of Tramadol is not indicated nor medically necessary.