

<b>Case Number:</b>	CM14-0068879		
<b>Date Assigned:</b>	07/14/2014	<b>Date of Injury:</b>	06/29/2000
<b>Decision Date:</b>	09/08/2014	<b>UR Denial Date:</b>	05/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/13/2014

### 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 Anesthesiology, has a subspecialty in Acupuncture & Pain 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 72-year-old female injured worker with date of injury 6/29/00 and related low back pain. Per progress report dated 4/8/14, she reported frequent, mild, aching low back pain, which occasionally increased to moderate. Her pain radiated to the left knee. She reported numbness of her right foot, and occasional numbness of her left foot. She also complained of back and calf muscle spasms. Per physical exam, there was 1+ tenderness to palpation of the lumbar spine at the midline, and 1+ lumbar paraspinal tenderness bilaterally without spasm. Magnetic resonance imaging (MRI) of the lumbar spine dated 9/25/03 revealed degenerative disc disease at L3-L4 and L5-S1, with no evidence of disc herniation. There was mild compromise of the neural foramina bilaterally at L5-S1. Treatment to date has included transcutaneous electrical nerve stimulation (TENS) unit, injections, acupuncture, chiropractic manipulation, physical therapy, and medication management. The date of UR decision was 5/5/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultram 50mg 1-2 by mouth (PO) every 6 hours (Q6) as needed (PRN) to wean with target of completely off the medication: 2 units/days requested: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Weaning of Medications Page(s): 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Weaning of Medications Page(s): 124.

**Decision rationale:** Per MTUS with regard to weaning from medications: "Opioids: For opioids a slow taper is recommended. The longer the patient has taken opioids, the more difficult they are to taper. The process is more complicated with medical comorbidity, older age, female gender, and the use of multiple agents. Gradual weaning is recommended for long-term opioid users because opioids cannot be abruptly discontinued without probable risk of withdrawal symptoms. (Benzon, 2005) Patients with complex conditions with multiple comorbidities (including psych disorders) should be referred to an addiction medicine/psychiatry specialist. Opioid weaning should include the following: (a) Start with a complete evaluation of treatment, comorbidity, psychological condition; (b) Clear written instructions should be given to the patient and family; (c) If the patient cannot tolerate the taper, refer to an expert (pain specialist, substance abuse specialist); (d) Taper by 20 to 50% per week of original dose for patients who are not addicted (the patient needs 20% of the previous day's dose to prevent withdrawal); (e) A slower suggested taper is 10% every 2 to 4 weeks, slowing to a reductions of 5% once a dose of 1/3 of the initial dose is reached; (f) Greater success may occur when the patient is switched to longer-acting opioids and then tapered; (g) Office visits should occur on a weekly basis; (h) Assess for withdrawal using a scale such as the Subjective Opioid Withdrawal Scale (SOWS) and Objective Opioid Withdrawal Scale (OOWS); & (i) Recognize that this may take months." The documentation submitted for review does not support the ongoing use of opioids, as there is no evidence of return to work or functional improvement. Weaning from Ultram is supported; however, as the request is unclear with regard to "2units/days", medical necessity cannot be affirmed. Therefore, the request is not medically necessary.