

Case Number:	CM14-0188801		
Date Assigned:	11/19/2014	Date of Injury:	04/02/2014
Decision Date:	01/07/2015	UR Denial Date:	10/13/2014
Priority:	Standard	Application Received:	11/12/2014

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 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:

This 49-year old packager reported injuries of her right wrist and shoulder due to pulling trays weighing 20-25 pounds on 4/2/14. She began care with her current primary treater on 5/22/14. A functional assessment questionnaire administered at the first visit documents only two activities that the patient has no difficulty performing: speaking and smelling. The patient reports difficulty with all other activities included in the questionnaire, including great difficulty lifting a full glass to her mouth, washing and drying herself, sitting, doing light housework, opening a car door and shopping. Diagnoses included right shoulder strain, status post drainage of ganglion cyst on the right wrist, clinical carpal tunnel syndrome, and right upper extremity neuropathy/radiculopathy. Treatment included a wrist splint, physical therapy, Naproxen, Gabapentin, and topical compounded creams. On 6/19/14 the primary treater discontinued Naproxen and Gabapentin and started Tramadol 50 mg. Cyclobenzaprine was added on 8/14/14. The provider continued to see the patient every month. Tramadol was carried forward through the last visit documented in the available records, 9/11/14, on which date the primary treater dispensed Tramadol ER 150 mg #30. Except for the first visit, this patient's functional status is not addressed in any of the primary provider's notes. No functional goals are ever documented. The patient's work status is always documented as modified, and the restrictions do not decrease during the documented time period. It is not documented whether or not the patient is actually working, but it appears likely that she is not. There is no significant change in the patient's complaints or physical exam over the period from 5/22/14 to 9/11/14. She continues to have tenderness and limited range of motion of the right shoulder and of her wrists and hands. Her diagnoses are never modified; despite upper extremity electrodiagnostic testing performed 7/15/14 which was normal, and specifically negative for carpal tunnel syndrome and for cervical radiculopathy. A urine drug screen was collected at every visit, and was negative for Tramadol

metabolites at all visits except for 7/17/14. The provider does not address the inconsistent results from the August visit in the 9/11 note. The 9/11/14 drug screen results were again negative for Tramadol metabolites. The Tramadol dispensed on 9/11/14 was non-certified in UR on 10/13/14 on the basis that Tramadol is not a first line oral analgesic, and that documentation was lacking as to why Tramadol was started.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for 30 tablets of Tramadol extended release 50 mg, dispensed on 9/11/14: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic Pain, Criteria for Use of Opioids, Steps to Take Before a Therapeutic Tr. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Up-to-date, an online evidence-based review service for clinicians (www.uptodate.com), Tramadol: Drug Information.

Decision rationale: Per the MTUS recommendations cited above, medications should be trialed one at a time while other treatments are held constant, with careful assessment of function, and there should be functional improvement with each medication in order to continue it. Opioids should not be started without an evaluation of the patient's current status in terms of pain control and function. An attempt should be made to determine if the patient's pain is nociceptive or neuropathic. Red flags indicating that opioid use may not be helpful should be identified, as should risk factors for abuse. Specific functional goals should be set, and continued use of opioids should be contingent on meeting these goals. Opioids should be discontinued if there is no improvement in function or if there is a decrease in function. Opioids are not recommended as first-line therapy for neuropathic pain. The response of neuropathic pain to drugs may depend on the cause of the pain. Per the Up-to-date reference cited above, Tramadol increases the risk of seizures even at recommended doses. This risk is increased in patients on other opioids or Cyclobenzaprine. The clinical documentation in this case does not support the use of Tramadol for this patient. There is no documentation of evaluation of whether or not the patient's pain is nociceptive or neuropathic. Some of the documented symptoms as well as diagnoses (cervical radiculopathy) and treatments (Gabapentin) make it appear that the patient's pain is neuropathic. Neuropathic pain does not necessarily respond well to opioids. No assessment was made of whether or not opioid use was likely to be helpful in this patient, or of her potential for abuse. No specific functional goals were set or followed. Importantly, Tramadol was not discontinued when it became clear that it has not produced any functional improvement. This patient's functional level does not appear to have improved in any way since Tramadol was introduced, and it is likely that she has remained off work. It is not clear if the patient continues to take Cyclobenzaprine since no discontinuation of it was documented. As discussed above, this patient's risk of having a seizure is increased by the combination of Tramadol with Cyclobenzaprine. Finally, the patient's most recent drug screens (8/14/14 and 9/11/14) would

suggest that she is not taking Tramadol at all. This issue should definitely have been addressed prior to dispensing more Tramadol to her. It is possible that she finds it ineffective, that it has intolerable side effects, or that she is diverting it. None of these situations warrant the continued use of Tramadol. Based on the clinical information available for my review and on the evidence-based citations above, Tramadol ER 150 mg #30 is not medically necessary. It is not medically necessary because no appropriate evaluation of the patient was made before it was started, because no functional goals for its use were set or monitored, because its combination with Cyclobenzaprine puts the patient at risk for seizures, and because the patient does not actually appear to be taking Tramadol according to her two most recent drug screens.