

<b>Case Number:</b>	CM14-0192851		
<b>Date Assigned:</b>	12/19/2014	<b>Date of Injury:</b>	05/31/2006
<b>Decision Date:</b>	01/21/2015	<b>UR Denial Date:</b>	11/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2014

### 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 Utah. 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 patient is a 47 year-old female. The patient's date of injury is 5-31-2006. The mechanism of injury is not stated, only that patient developed numbness and pain her hands and upper extremities. The patient has been diagnosed with upper extremity overuse syndrome, bilateral elbow olecranon bursitis, bilateral wrist sprain, DeQuervain's' tenosynovitis, right sacroiliac sprain, cervical sprain, shoulder impingement, right knee sprain and carpal tunnel syndrome. The patient's treatments have included a home exercise program, work restrictions, and medications. The physical exam findings dated December 11, 2013 shows the lumbar spine with her paravertebral muscles tender. There is a spasm noted as present. The range of motion is restricted. The straight leg testing is positive bilaterally and sensation is noted to be reduced in the right L5 dermatome distribution. The patient's medications have included, but are not limited to, Ultram and Ambien. The request is for Ultram.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultram ER 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 Opioids, criteria for use Page(s): 75-79.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The MTUS indicates that ongoing management of opioids includes documentation of prescriptions given from a single practitioner, prescriptions from a single pharmacy and the lowest dose should be used to improve function. There should also be an ongoing review of the 4 A's, including analgesia, activities of daily living, adverse side effects, and aberrant drug behaviors. There is no clear functional gain that has been documented with this medication. In addition, according to the documentation provided, there has been no significant change in character of the pain; the pain appears to be chronic, lacking indications for short acting pain control medications. According to the clinical documentation provided and current MTUS guidelines; Ultram is not indicated a medical necessity to the patient at this time.