

<b>Case Number:</b>	CM14-0193356		
<b>Date Assigned:</b>	12/01/2014	<b>Date of Injury:</b>	06/23/2011
<b>Decision Date:</b>	01/13/2015	<b>UR Denial Date:</b>	11/04/2014
<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 Internal 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 injured worker (IW) is a 66-year-old man with a date of injury of June 23, 2011. The mechanism of injury occurred when the IW tried to forcefully push open a door while holding a heavy box full of garbage bags. The IW felt a crack, and his right leg had no more strength after the incident. Subsequently, the IW had difficulty walking and sitting. Pursuant to the office visit note dated September 17, 2014, the IW presents for follow-up of his lower back and right leg pain. He is status post right knee arthroscopy surgery on April 2, 2012 with significant improvement in his pain. He suffered a CVA on June 17, 2012 and has residual left-sided weakness despite completing rehabilitations. He ambulates with the assistance of a cane. He complains of back pain with radiation to his right leg. He states that the medication is very helpful in reducing his pain. He is able to sleep better with the use of medications. Physical examination reveals normal muscle tone without atrophy in the bilateral lower extremities. There is no other objective findings documented pertaining to the back or right leg. The IW has been diagnosed with lumbar disc displacement without myelopathy; degenerative lumbar disc disease; pain in joint, lower leg. Current medications include Orphenadrine-Norflex Er 100 mg, Tramadol Hcl Er 150 mg, Tramadol/APAP 37.5/325 mg, Atenolol 25 mg, Famotidine 20 mg, Fenofibrate 160 mg, Glipizide 10 mg, Glucophage Xr 750 mg, Lisinopril 10 mg, Metformin Hcl 1000 mg, Simvastatin 40 mg, Clopidogrel 75 mg, Niacin (OTC), and Omega 3 (OTC). The treating physician is requesting authorization for Tramadol/APAP 37.5/325 mg #90. Documentation in the medical record indicated that the IW has been taking Tramadol/APAP since at least April of 2014. There were no pain assessments in the medical record or documentation of objective function improvement while on the stated pain medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol/APAP 37.5/325 mg 1-2 PO PRN #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opiates Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain Section, Opiates

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Tramadol/APAP 37.5/325 mg 1 to 2 tablets PO PRN #90 is not medically necessary. Ongoing, chronic opiate use requires an ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. Detailed pain assessments should accompany chronic opiate use. Satisfactory response to treatment may be indicated by the patient's decreased pain, decrease level of function or improved quality of life. The lowest possible dose should be prescribed to improve pain and function. In this case, the injured worker is being treated for lumbar disc displacement without myelopathy, degeneration lumbosacral disc and pain and joint lower leg. The documentation indicates the injured worker is taking both Tramadol ER 150 mg capsules #31 tablet per day at dinner time and Tramadol/APAP 37.5/325 mg #90, 1 to 2 tablets as needed for pain. The earliest progress note indicates the injured worker is taking Tramadol since April 20 of 2014. The start date is unclear in the medical record. Although the injured worker states subjective improvement there is no objective functional improvement documented in the medical record. There is no documentation in the medical record as to whether the injured worker took first-line medications such as non-steroidal anti-inflammatory medications, antiepileptic medications or tries cyclic antidepressants for the back and leg symptoms. The documentation states the injured workers are taking a blood thinner (Plavix). There is no detailed pain assessment in the medical record, no risk assessment in the medical record and no pain contract in the medical record. There are no urine drug screens to monitor opiate compliance in the medical record. Consequently, absent the appropriate clinical documentation and evidence of objective functional improvement of opiate use (Tramadol ER 150 Mg and Tramadol/APAP 37.5/325 mg #90); Tramadol/APAP 37.5/325 mg #90 is not medically necessary.