

Case Number:	CM14-0199479		
Date Assigned:	12/09/2014	Date of Injury:	06/08/2012
Decision Date:	01/27/2015	UR Denial Date:	11/04/2014
Priority:	Standard	Application Received:	11/26/2014

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 Orthopedic Surgery 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 50 year old injured worker (IW) sustained an industrial injury of the back and left shoulder on 06/08/2012. According to the peer review letter of 11/04/2014, the IW has had chiropractic therapy, work conditioning, epidural steroid injections, a left shoulder injection, medication, and activity modifications over the life of the claim.. Included in the medical record received for the Independent Medical Review (IMR) are physician care notes dated 05/29/2014 and the follow up examination notes of 07/22/2012. On the 07/22/2014 date, the chief complaints were constant right lower back, right knee pain and pain in the right calf, right hip and right toes. Other complaints include headaches, right mid and left upper back pain, sacroiliitis, and right shoulder pain. The back, right lower extremity, and sacroiliitis are rated by the IW as a 9 on a scale of 10 and the pain is reduced by lying down, medication and resting. The right mid and left upper back is rated an 8 on a scale of 10, and the right shoulder pain is rated a 7 on the scale of 10. All of the complaints were responsive to rest and medication. Additional complaints are decreased range of motion, increased sensitivity and weakness. The IW had right shoulder surgery on 01/10/2014, received physical therapy and is doing home exercises. On physical exam, the IW has decreased flexion, and extension on the cervical and lumbar spine with decreased rotation in the dorsal lumbar spine, and decreased movements and range of motion in the right and left shoulders. The IW 's diagnosis include lumbar facet syndrome, lumbar non allopathic lesions, sacroiliitis, left shoulder tenosynovitis, cervicalgia, lumbar muscle spasms, cervical myalgia/myofascitis, cervical non allopathic lesions, post traumatic headaches, thoracalgia, and bilateral shoulder impingement r/o derangement . The plan of care includes medications of Norco 10 mg up to 4 times a day, Atarax 25 mg as needed for sleep, Naproxen 1 tablet twice daily, Prilosec 20 mg daily, Cyclobenzaprine 7.5 mg up to three times a day, Prozac 20 mg twice daily to decrease symptoms of anxiety and depression from what was documented as probable

post-traumatic anxiety and depression, and Tramadol ER 150 mg one to two tablets daily. Separate requests for authorization were made for each medication as needed. Tramadol/Ultram 150 mg-Extended Release (ER) 150 mg was ordered for breakthrough neuropathic pain control and to improve function. On 10/17/2014, a request for authorization (ROA) form was submitted requesting Tramadol 150 mg #30 /30 day's duration -#90. Dosage and frequency were in an attached report. After reviewing provider records from 04/17/2014 through 09/17/2013 that were inclusive of visit notes, a peer review of 09/09/2014, medication records and a MRI of the right shoulder, the Utilization Review (UR) dated 11/04/2014 non-certified the request for Tramadol stating the clinical findings do not appear to support the medical necessity of the treatment. The CA-MTUS (California Medical Treatment Utilization Schedule) Guidelines Chronic pain was referenced for the decision. On requested an independent medical review of the denial of Tramadol 150 ER 1-2xprn #90 30 d (Max MED 100). Reports of the MRI of the lumbar spine completed June 24, 2012 and reviews of notes from 09.09/2014 through 10/14/2014 are included in the UR peer clinical review report.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 150 ER #90 30d (Max Med 100): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80. Decision based on Non-MTUS Citation Title 8, California Code of Regulations

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbar facet syndrome, lumbar non-allopathic lesions, sacroiliitis, left shoulder tenosynovitis, cervicalgia, lumbar muscle spasms, cervical myalgia/myositis, cervical non-allopathic lesions, headaches, thoracalgia, and right and left shoulder impingement rule out derangement. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; that the lowest possible dose is being prescribed; and that there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, given medical records reflecting prescription for Tramadol ER since at least 5/14, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Tramadol ER use to date. Therefore, based on guidelines and a review of the evidence, the request for Tramadol 150 ER #90 30d (Max Med 100) is not medically necessary.

