

<b>Case Number:</b>	CM14-0089409		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	07/02/2004
<b>Decision Date:</b>	02/23/2015	<b>UR Denial Date:</b>	05/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/13/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, Illinois  
 Certification(s)/Specialty: Internal Medicine

### 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 is a 63-year-old male who reported an injury on 07/02/2004. Insert relevant diagnoses here>His diagnoses included degeneration of the lumbar intervertebral discs and chronic pain syndrome. His past treatments were not provided within the submitted documentation for review. Diagnostic studies were not provided within the submitted documentation for review. His surgical history includes a shoulder surgery. The injured worker presented on 05/22/2014 with complaints of radiating low back pain to the bilateral lower extremities. He also reported numbness and tingling. Upon physical examination of the lumbar spine, soft tissue palpation on the right revealed tenderness of the paraspinal region at the L4 and the iliolumbar region, and no tenderness of the piriformis. Soft tissue palpation on the left revealed tenderness of the paraspinal region at the L4 and the iliolumbar region, and no tenderness of the piriformis. The neurological examination of the bilateral lower extremities was abnormal. His current medication regimen includes Ativan, Duexis, Singulair, tramadol, and Ultram since at least 05/22/2014. The treatment plan included a prescription for Ultram ER 100 mg 100 mg tablet, extended release, take 1 tablet every day by mouth for 30 days #30 with 2 refills and tramadol 50 mg take 1 tablet a day by mouth as needed for 30 days #45 with 2 refills. The treatment plan further recommended that the injured worker try Ultram ER, as the injured worker had taken 2 Ultram but was no better when the pain was severe. The treatment plan further states if his back adhesive capsulitis up will recommend facet/ESI. The physician recommended exercise, weight loss, and stretching. The rationale for the request was for chronic

pain. A Request for Authorization Form was not provided within the documentation submitted for review.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Ultram ER 100mg, #30 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 93-94.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-78.

**Decision rationale:** The request for Ultram ER 100mg, #30 with 2 refills is not medically necessary. The injured worker has chronic radiating low back pain. The California MTUS Guidelines state the ongoing management of opioid therapy should include detailed documentation of pain relief, functional status, appropriate medication use, and side effects. The submitted documentation did not include a detailed pain assessment to establish adequate pain relief with the use of Ultram ER. There was also no evidence of functional improvement or lack of adverse effects and aberrant behaviors. Additionally, a urine drug screen was not submitted to verify appropriate medication use. In the absence of documentation showing details regarding the injured worker's medication, including his use of Tramadol and the appropriate documentation to support the ongoing use of opioids, the request is not supported. As such, the request for Ultram ER 100mg, #30 with 2 refills is not medically necessary.

**Tramadol 50mg, #45 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 93-94.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76-78.

**Decision rationale:** The request for Tramadol 50mg, #45 with 2 refills is not medically necessary. The injured worker has radiating low back pain. The California MTUS Guidelines state the ongoing management of opioid therapy should include detailed documentation of pain relief, functional status, appropriate medication use, and side effects. The submitted documentation did not include a detailed pain assessment to establish adequate pain relief with the use of Tramadol. There was also no evidence of functional improvement or a lack of adverse effects and aberrant behaviors. Additionally, a urine drug screen was not submitted to verify appropriate medication use. In the absence of documentation showing details regarding the injured worker's medications, including his use of Tramadol and the appropriate documentation to support the ongoing use of opioids, the request is not supported. As such, the request for Tramadol 50mg, #45 with 2 refills is not medically necessary.

