

Case Number:	CM15-0047004		
Date Assigned:	04/06/2015	Date of Injury:	10/07/2011
Decision Date:	05/01/2015	UR Denial Date:	03/06/2015
Priority:	Standard	Application Received:	03/12/2015

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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 44-year-old male, with a reported date of injury of 10/07/2011. The diagnoses include right forearm fracture with surgical repair, reflex sympathetic dystrophy, intermittent right shoulder pain, and occasional low back pain. Treatments to date have included oral medications, an MRI of the right wrist, and open reduction internal fixation of the right wrist. The progress report dated 02/03/2015 indicates that the injured worker had ongoing right upper extremity pain and hypersensitivity. He needed refills of his medications. The random urine drug screen that was performed the day of the visit was positive for Tramadol and consistent. The objective findings include no flexion or lateral rotation of the right wrist, minimal ability to pronate and supinate the forearm, full range of motion of the right shoulder, and hypersensitivity to the distal right forearm. The treating physician requested Tramadol and a urinalysis drug screen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Tramadol 50 MG Qty 200 DOS 2/3/15: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing management Page(s): 78-80.

Decision rationale: Retro Tramadol 50 MG Qty 200 DOS 2/3/15 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS Chronic Pain Medical Treatment Guidelines state that a pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The MTUS does not support ongoing opioid use without improvement in function or pain. The documentation submitted does not reveal the above pain assessment or clear monitoring of the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). For these reasons, the request for retro Tramadol is not medically necessary.

Retro UA Drug Screen DOS 2/3/15: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, drug screens, steps to avoid misuse/addiction and Opioids, steps to avoid misuse/addiction Page(s): 77-80, and 94. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic)- Urine drug testing (UDT) and Other Medical Treatment Guidelines Updated ACOEM Guidelines, 8/14/08, Chronic Pain, Page 138, urine drug screens.

Decision rationale: Retro UA Drug Screen DOS 2/3/15 is not medically necessary per the MTUS Guidelines. There is no evidence in this case that opioids are prescribed according to the criteria outlined in the MTUS. The MTUS recommends random drug testing, not at office visits or regular intervals. It is unclear how many prior urinalysis the patient has had. The ODG patients at "low risk" of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. There is no evidence of aberrant behavior in the documentation submitted. The documentation does not indicate that the Tramadol is medically necessary. For all of these reasons the request for retro UA drug screen DOS 2/3/15 is not medically necessary.