

Case Number:	CM15-0050325		
Date Assigned:	03/23/2015	Date of Injury:	12/20/2008
Decision Date:	05/01/2015	UR Denial Date:	02/28/2015
Priority:	Standard	Application Received:	03/17/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 65-year-old male with an industrial injury dated December 20, 2008. The injured worker diagnoses include cervical spine degenerative disc disease and spondylosis, chronic cervical spine strain, bilateral shoulder rotator cuff syndrome, bilateral shoulder acromioclavicular arthrosis, left thumb carpal metacarpal arthrosis, left thumb FCU (flexor carpi ulnaris) tendinitis, lumbar spine degenerative disc disease and spondylosis with likely radiculopathy, bilateral knee arthrosis, status post right total knee arthroplasty, anxiety/depression symptoms and gastrointestinal symptoms. Treatment consisted of diagnostic studies, prescribed medications and periodic follow up visits. In a progress note dated 02/10/2015, cervical exam revealed mild tenderness to palpitation and mild to moderate pain at limits of cervical motion. Bilateral shoulder exam revealed tenderness to palpitation. Lumbar spine exam revealed tenderness to palpitation and decrease lower extremity sensation. The treating physician prescribed Tramadol/APAP 37.5/325mg #60 now under review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol/APAP 37.5/325mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: Based on the 2/10/15 progress report provided by the treating physician, this patient presents with unchanged, constant neck pain radiating to the right upper extremity including anterior chest and posterior shoulder, as well as bilateral shoulder pain, left hand pain, bilateral knee pain and low back pain. The treater has asked for TRAMADOL/APAP 375/325mg #60 on 2/10/15. The patient's diagnoses per Request for Authorization form dated 2/10/15 are cervical spine degenerative disc disease and spondylosis, cervical spine strain, chronic bilateral shoulder rotator cuff syndrome, bilateral shoulder acromioclavicular arthrosis, left thumb carpal-metacarpal arthrosis, left thumb FCU tendinitis, lumbar spine degenerative disc disease and spondylosis with likely radiculopathy, bilateral knee arthrosos, right advanced, left moderate s/p right total knee arthroplasty 1/20/14 psyche anxiety and depression symptoms "internal" gastrointestinal symptoms. The patient is s/p lumbar epidural steroid injection from 2/24/12 which helped, a second epidural steroid injection 6/29/12 which helped 50% for 3-4 weeks per 2/10/15 report. The patient is currently using a cane for ambulation per 2/10/15 report. The patient has had 22 outpatient physical therapy sessions of unspecified benefit per 9/30/14. Before doing the 22 sessions of physical therapy, the patient was walking a block and standing for less than 1 minute per 9/30/14 report. The patient's current medications are Hydrocodone, Tramadol, Pepcid, and Colace per 8/12/14 report. The patient's work status is partial disability with permanent restrictions, and cannot return to employment with usual / customary duties as of 2/10/15. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Tramadol has been included in patient's medications per treater reports dated 8/12/14, 9/30/14, and 2/10/15. In this case, treater states that patient "does take medications" Norco and Tramadol "for knee pain which provides satisfactory relief" per 2/10/15 report. However, the patient has not stated how Tramadol has significantly improved the patient's activities of daily living. There are no pain scales or validated instruments addressing analgesia. There are no specific discussions regarding aberrant behavior, adverse reactions, ADL's, etc. No urine drug screens were mentioned in provided reports. No opioid pain agreement or CURES reports were included in the documentation. No return to work, or change in work status, either. MTUS requires appropriate discussion of the 4A's. Given the lack of documentation as required by guidelines, the request IS NOT medically necessary.