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| <b>Case Number:</b>   | CM15-0060415 |                              |            |
| <b>Date Assigned:</b> | 04/06/2015   | <b>Date of Injury:</b>       | 02/19/2013 |
| <b>Decision Date:</b> | 05/05/2015   | <b>UR Denial Date:</b>       | 03/25/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 03/30/2015 |

### 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: New Jersey, New York  
 Certification(s)/Specialty: Family Practice

### 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 61-year-old male, who sustained an industrial injury on 02/19/2013 reported left knee pain, lower back pain, right/left elbow pain and cervical spine pain. On provider visit, 10/03/2014 the injured worker has reported on examination of the cervical spine was noted as decreased /painful range of motion and tenderness, the right elbow was noted as decreased range of motion with pain and tenderness, left elbow was noted as tenderness, painful and decreased range of motion. Lumbosacral spine was noted to have a positive straight leg raise, tenderness and decreased/painful range of motion and left knee was noted to have pain with range of motion, tenderness, atrophy and decreased strength. The diagnoses have included cervical pain with radiculitis, right and left elbow pain, lumbosacral pain with sciatica and left knee pain. Treatment to date has included MRI and x-ray, medications, physical therapy, injections, and shockwave treatment. The provider requested Tramadol for pain management.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol tablets 50 mg (take 1-2 every 6 hours as needed) Qty 120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram); Opioids Page(s): 113, 75, 80, 82-84, 78-79, 81, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids  
Page(s): 78-79.

**Decision rationale:** The request for Tramadol is medical unnecessary. There is no documentation of what his pain was like previously and how much Tramadol decreased his pain. There is no documentation all of the 4A's of ongoing monitoring: pain relief, side effects, physical and psychosocial functioning and aberrant drug-related behaviors. Side effects were not documented. There was no documentation of objective improvement in functional capacity. There were no urine drug screenings or drug contract. Because of these reasons, the request for Tramadol is considered medically unnecessary.