

Case Number:	CM14-0124077		
Date Assigned:	10/07/2014	Date of Injury:	03/01/1993
Decision Date:	10/30/2014	UR Denial Date:	07/19/2014
Priority:	Standard	Application Received:	08/06/2014

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 Occupational Medicine 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:

Patient with reported date of injury on 3/1/1993. Mechanism of injury is described as a lifting injury. Patient has diagnosis of chronic pain syndrome, lumbago, lumbosacral spondylosis, lumbar disc degeneration, obesity and sacroiliitis. Patient also has a history of non-industrial burns to R side of body. Medical reports reviewed. Last report available until 9/9/14. Patient complains of low back pain R side worse than L side. Pain causes spasms and is associated with numbness to lateral aspect of both thighs along with burning sensation to bottom of feet. Objective exam reveals discomfort, positive straight leg raise bilaterally; diffuse facet tenderness, SI joint tenderness on R side with positive compression, FABER, thigh thrust and Ganslen test. Limited range of motion. Diminished sensation to bilateral lateral femoral cutaneous nerves and distal peripheral distribution. Tramadol was reportedly "helpful". Using 2-3 tablets per week. Pain is reportedly 3-4/10 at baseline and worsens to 9-10/10 at times. Urine Drug Screen was appropriate. Appropriate monitoring. MRI of lumbar spine (9/28/10) revealed multi-level loss of disc height and disc desiccation. Facet arthropathy. Disk osteophyte complex at L3 with displacement of lateral aspect of R L3 nerve root. Disk osteophyte complex at L4-5 with contact of L side L4 nerve root. Medication list include Amlodipine, Aspirin, Losartan and Ultracet. Patient has had physical therapy, acupuncture, diagnostic medial branch blocks and radio frequency ablation with no improvement. Independent Medical Review is for Tramadol/Acetaminophen 37.5/325 mg #90. Prior UR on 10/13/14 recommended non-certification.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol-Acetaminophen 37.5/325mg #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Tramadol/ Ultram is a Mu-agonist, an opioid-like medication. As per MTUS Chronic pain guidelines, documentation requires appropriate documentation of analgesia, activity of daily living, adverse events and aberrant behavior. Documentation meets the appropriate documentation required by MTUS. 4 A's of documentation are met. However, the number of prescribed tablets is excessive and does not meet MTUS guidelines for close monitoring. Patient reportedly uses 2-3 tablets a week. The prescribed 90 tablets would give the patient over 7-8 months of medications. The prescription for Tramadol as currently written is not medically necessary.