

<b>Case Number:</b>	CM14-0110650		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	12/31/2008
<b>Decision Date:</b>	07/16/2015	<b>UR Denial Date:</b>	06/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/15/2014

### 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: New Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, 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 49 year old female, who sustained an industrial injury on December 31, 2008. The injured worker was diagnosed as having lumbago, lumbosacral neuritis, lumbar spinal stenosis and sacroiliac sprain. Treatment to date has included injection and medication. A progress note dated June 11, 2014 provides the injured worker complains of right leg pain rated 6-7/10 due to a recent flare up. Her previous injection was effective for sacroiliac joint pain. Physical exam notes an antalgic gait, right sacroiliac joint tenderness with limited range of motion (ROM) of the hip. The lumbar area is tender on palpation with painful decreased range of motion (ROM) and positive straight leg raise. Review of magnetic resonance imaging (MRI) reveals disc degeneration, facet arthropathy and disc narrowing. Electromyogram and nerve conduction study shows active radiculopathy. The plan includes Tramadol, Meloxicam, Elavil and epidural steroid injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 prescription of Tramadol HCL, 50mg #90 with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Long-term Users of Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol  
Page(s): 113.

**Decision rationale:** According to MTUS guidelines, Ultram (Tramadol) is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework. Although, Tramadol may be needed to help with the patient pain, there is no clear evidence of objective and recent functional and pain improvement from its previous use. There is no clear documentation of the efficacy/safety of previous use of tramadol. Therefore, the prescription of Tramadol HCL 50mg #90 with 1 refill is not medically necessary.

**1 prescription of Meloxicam 15mg #30 with 1 refill: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Meloxicam (Mobic).

**Decision rationale:** According to MTUS guidelines, Mobic (Meloxicam) is a non-steroidal anti-inflammatory drug (NSAID) for the relief of the signs and symptoms of osteoarthritis. There is no documentation that the patient is suffering of osteoarthritis pain. Furthermore and according to MTUS guidelines, Chronic Pain Medical Treatment Guidelines chapter, NONSELECTIVE NSAIDS section, Mobic is indicated for pain management of breakthrough of neck or back pain. The medication should be used at the lowest dose and for a short period of time. Although the patient developed a chronic back pain that may require Mobic, there is no documentation that the provider recommended the lowest dose for the shortest period of time. There is no documentation of pain and functional improvement with previous use of NSAID. Therefore, the prescription of Meloxicam 15mg #30 with 1 refill is not medically necessary.