

Case Number:	CM15-0179440		
Date Assigned:	09/21/2015	Date of Injury:	02/21/2000
Decision Date:	10/27/2015	UR Denial Date:	08/13/2015
Priority:	Standard	Application Received:	09/11/2015

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: Emergency 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 62-year-old female who sustained an industrial injury on 2-21-2000. A review of medical records indicates the injured worker is being treated for chronic pain syndrome, lateral epicondylitis of the elbow, carpal tunnel syndrome, lumbago, degeneration of lumbar or lumbosacral intervertebral disc, and cervical spondylosis without myelopathy. Medical records dated 6-5-2015 noted bilateral wrist pain with right side worse than the left. Worst pain was an 8 out 10, least pain was a 2 out 10, and usual pain was a 5 out 10. Functionality was better. Medical records dated 12-8-2014 noted worst pain an 8 out 10, least pain a 4 out 10, and usual pain a 6 out 10. Physical examination dated 6-5-2015 noted tenderness to palpation over the lateral and medial epicondyles of both right and left elbow. She has full range of motion of both wrists without arthritis deformities. Scars of previous surgeries were noted to both wrists. Treatment has included physical therapy, injections, and medications. Utilization review form dated 8-13-2015 noncertified Tramadol-APAP.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol/Acetaminophen (unspecified dosage, frequency): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: Tramadol is a direct Mu-agonist, an opioid-like medication. As per MTUS guidelines, opioids should only be used for moderate-severe pain and after appropriate assessment of alternative. There is not a single mention of why Tramadol is being prescribed. Patient has been stable on non-opioid medications and reportedly had improvement in pain after injections. Documentation fails to specify any justification for Tramadol use. This request is also incomplete with no dose, frequency or tablets requested. This is an incomplete and inappropriate request. This request is not medically necessary.