MAXIMUS Federal Services

Case Number:	CM15-0072369		
Date Assigned:	04/27/2015	Date of Injury:	11/07/2012
Decision Date:	05/22/2015	UR Denial Date:	03/27/2015
Priority:	Standard	Application Received:	04/15/2015

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: Iowa, Illinois, Hawaii
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 57-year-old male, who sustained an industrial injury on November 7, 2012. He reported shoulder and knee pain. The injured worker was diagnosed as having status post-surgical interventions of the bilateral knees and right shoulder, discogenic sciatic radiculopathy, mechanical low back pain syndrome, loss of motion of the lumbar spine and abnormal posture. Treatment to date has included radiographic imaging, diagnostic studies, surgical interventions, shockwave therapy, physical therapy, medications and work restrictions. Currently, the injured worker complains of continued shoulder pain and decreased range of motion. The injured worker reported an industrial injury in 2012, resulting in the above noted pain. He was treated conservatively and surgically without complete resolution of the pain. Evaluation on October 27, 2014, revealed continued shoulder pain and decreased range of motion. He reported no pain with movement in bilateral knees. A retrospective request for pain medication was made.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Tramadol 150 MG XR #30 (DOS 2-12-15): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Tramadol, Ultram Page(s): 74-96, 113, 123. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) - Medications for acute pain (analgesics), Tramadol (Ultram).

Decision rationale: Tramadol is classified as a central acting synthetic opioids. MTUS states regarding tramadol that "A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals." ODG further states, "Tramadol is not recommended as a first-line oral analgesic because of its inferior efficacy to a combination of Hydrocodone/ acetaminophen." The treating physician did not provide sufficient documentation that the patient has failed a trial of non-opioid analgesics at the time of prescription or in subsequent medical notes. Additionally, no documentation was provided which discussed the setting of goals for the use of tramadol prior to the initiation of this medication. MTUS states that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. As such, the request for Retro Tramadol 150 MG XR #30 (DOS 2-12-15) is not medically necessary.