

Case Number:	CM15-0074248		
Date Assigned:	04/24/2015	Date of Injury:	10/02/1993
Decision Date:	05/21/2015	UR Denial Date:	04/09/2015
Priority:	Standard	Application Received:	04/20/2015

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: Preventive Medicine, Occupational 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 67 year old male, who sustained an industrial/work injury on 10/2/93. He reported initial complaints of back pain. The injured worker was diagnosed as having lumbar facet arthropathy, lumbar disc syndrome, acute muscle spasm, history of lumbar radiculopathy, myofascial pain, low back fusion (1999) with one sided fusion failure. Treatment to date has included medication, diagnostics, surgery, lumbar support brace, and activity modification. MRI results were reported on 2012. Currently, the injured worker complains of ongoing low back and knee pain and mood disruptions due to pain. Per the primary physician's progress report (PR-2) on 3/19/15, examination revealed muscle spasms in the lumbar paraspinal musculature (R>L), limited range of motion, hypersensitivity along the S1 dermatomal pattern, difficulty with heel walking, positive straight leg raise and Kemp's test on the lower L5-S1. There is tenderness in the medial aspect with some swelling in the left knee, flexion causes pain. The requested treatments include Ultram ER, Norco 7.5 mg, and retrospective urine drug screen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultram ER 150mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids section Weaning of Medications section Page(s): 74-95, 124.

Decision rationale: Tramadol is a central acting synthetic opioid that exhibits opioid activity with a mechanism of action that inhibits the reuptake of serotonin and norepinephrine with side effects similar to traditional opioids. The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. This injured worker has no significant decrease in subjective pain or objective evidence of improved function with Ultram. It is not recommended to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to continue treatment. The request for Ultram ER 150mg #30 is determined to not be medically necessary.

Retrospective urine drug screen: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing section Opioids Criteria for Use section Page(s): 43, 112.

Decision rationale: The use of urine drug screening is recommended by the MTUS Guidelines, in particular when patients are being prescribed opioid pain medications and there are concerns of abuse, addiction, or poor pain control. The request for retrospective urine drug screen is determined to be medically necessary.