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| Case Number: | CM14-0140723 | | |
| Date Assigned: | 09/10/2014 | Date of Injury: | 10/09/2013 |
| Decision Date: | 10/15/2014 | UR Denial Date: | 08/28/2014 |
| Priority: | Standard | Application Received: | 08/29/2014 |

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 Physical Medicine and Rehabilitation 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:

The injured worker is a 57-year-old male who reported an injury on 10/09/2013 due to a heavy lifting injury. On 08/13/2014, the injured worker presented with constant to moderate severe right shoulder and low back pain radiating to the lower extremities. Upon examination, there was decreased range of motion to the right shoulder with tenderness noted. There was decreased range of motion to the lumbar spine with tenderness. The diagnoses were inflammatory process of the right shoulder with stiff shoulder syndrome and myoligamentous strain of the lumbar spine with radicular symptoms in the bilateral lower extremities. Medications included Terocin patches and tramadol. The provider recommended retrospective Ultram ER 150 mg #30. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro (DOS 7/16/14) Ultram ER 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78- 80; 93 and 94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use, Page(s): 78..

Decision rationale: The request for Retro (DOS 7/16/14) Ultram ER 150 mg #30 is not medically necessary. The California Guidelines recommend the use of opioids for ongoing management of chronic pain. The Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is a lack of documentation of an objective assessment of the injured worker's pain level, functional status, evaluation for risk of aberrant drug abuse behavior, and side effects. The efficacy of the prior use of the medication was not provided. Additionally, the frequency of the medication was not provided in the request as submitted. As such, medical necessity has not been established.