

<b>Case Number:</b>	CM13-0017911		
<b>Date Assigned:</b>	10/11/2013	<b>Date of Injury:</b>	07/06/2009
<b>Decision Date:</b>	01/07/2014	<b>UR Denial Date:</b>	07/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/09/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & 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 physician 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 underlying date of injury in this case is 07/06/2009. The primary diagnosis is 717.0 or a bucket handle tear of the meniscus of the knee. The patient is a 52-year-old man whose mechanism of injury was a motor vehicle accident. The claim has been accepted for the low back and the right knee. The patient is status post right knee surgery. Radiographic studies have demonstrated tricompartmental degenerative arthritis of the right knee. Preoperative risk assessment of 09/25/2013 indicates at that time the patient was evaluated for preoperative reassessment for proposed right total knee replacement since the patient had ongoing symptoms and failed conservative treatment. The records note the patient also is status post a prior knee arthroscopy. An initial physician review notes that as of 06/26/2013 the patient reported a steroid injection in the right knee did not help much. The patient was diagnosed with right knee osteoarthritis with lack of motion. The treatment plan included reordering tramadol as well as a cold therapy unit to allow the patient to ice his knee, noting he was icing his knee almost 3-4 times per day. The initial physician reviewer noted that there was no documentation of a pain contract and the patient did not meet standards for opioid prescribing, and therefore this was noncertified. Cold therapy was noncertified with the rationale that this was not an immediate postoperative request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 9th Edition (web), chronic pain, Tramadol..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol, Opioids Page(s): 113, 77.

**Decision rationale:** The MTUS Chronic Pain Guidelines suggests that Tramadol "is not recommended as a first-line oral analgesic." The MTUS Chronic Pain Guidelines also state, "A written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, the treatment plan, and the informed consent." In this case, the patient has substantial ongoing pain with gait limitations documented in the medical record which represent functional limitations. The records outline multiple methods to improve the patient's function including potential surgery, physical therapy, and pharmacological treatment. In this chronic setting, the guidelines would support the use of Tramadol in order to avoid the greater dependence potential of first-line opioids, and therefore this request is supported by the guidelines. This request is medically necessary.

**Cold therapy:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 5th Edition, 2007, Arm and hand-Cold, Heat.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Initial Approaches to Treatment (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 3) page 48, and the Official Disability Guidelines Knee Chapter..

**Decision rationale:** ACOEM Guidelines state, "During the acute to subacute phases for a period of 2 weeks or less, physicians can use passive modalities such as application of heat and cold for temporary amelioration of symptoms and to facilitate mobilization and graded exercise." The guidelines, therefore, do not support the use of thermal modalities such as what is requested in this case in a chronic setting. The Official Disability Guidelines states regarding continuous-flow cryotherapy, "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use." This guideline, therefore, does not support this treatment in a chronic setting. During the period of the initial utilization review in this case, the request was not for immediate postoperative use but rather for ongoing use several times per day at home. This request is not medically necessary.