

<b>Case Number:</b>	CM13-0045381		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	04/16/2009
<b>Decision Date:</b>	02/24/2014	<b>UR Denial Date:</b>	11/03/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/11/2013

### 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 Family Practice 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:

47 yr. old male claimant sustained an injury on 4/6/09 that resulted in lower back pain, extremity paresthesias and bilateral groin pain. He developed erectile dysfunction to an industrial injury and dysuria due to ongoing diabetes. For his back he had received therapy, epidural injections and analgesics including Flexeril and Tramadol (Ultram) monthly since at least 2012. On April 24, 2012, the claimant had seen a urologist for follow -up for erectile dysfunction, irritative voiding, and inguinal area pain. His urine symptoms were attributed to diabetes. He was recommended to see a general surgeon for the inguinal hernia. Viagra had failed prior erectile symptoms and intracorporeal injections were considered. A visit in June 25, 2012 also concluded in a recommendation for penile injections. On September 20, 2012, his post void volume was minimal and was determined to have reached maximum medical improvement and considered permanent and stationary but was recommended to see a urologist several times a year for symptoms. An exam report on 10/24/13 indicated the claimant had persistent head and neck pain, spasms in the low back and numbness in the feet. The examination findings included a positive leg raise and diminished sensation in the L5-S1 dermatomes. The claimant also had subjective complaints of difficulty with bladder emptying, losing urine and sexual dysfunction. A recommendation was made to see a urologist and Ultram, Flexeril and Diclofenac were continued for symptomatic management.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Urologist evaluation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Incontinence in men. In: Schroeder A, et al, Guidelines on urinary incontinence. Arnhem, The Netherlands: European Association of Urology (EAU); 2009 Mar. p. 11-28.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Specialist Referral , page(s) 127 (Chapter 7).

**Decision rationale:** According to the ACOEM guidelines, a specialist referral may be made if the diagnosis is uncertain, extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A consultation is used to aid in diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or examinees' fitness for return to work. In this case, the diagnosis was established, the condition was permanent and stationary and treatment course had not changed. A Urology referral is not medically necessary.

**Prescription Flexeril 10mg, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain)..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41.

**Decision rationale:** According to the MTUS guidelines, Cyclobenzaprine (Flexeril) is more effective than placebo for back pain. It is recommended for short course therapy and has the greatest benefit in the first 4 days suggesting that shorter courses may be better. Those with fibromyalgia were 3 times more likely to report overall improvement, particularly with sleep. In this case the medication was used for over a year with no specific information on direct benefit or pain scales. Continued Flexeril use is not medically necessary.

**Prescription Ultram ER 200mg, #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 93-94.

**Decision rationale:** According to the MTUS Guidelines: Opioid analgesics and Tramadol have been suggested as a second-line treatment (alone or in combination with first-line drugs). A recent consensus guideline stated that opioids could be considered first-line therapy for the following circumstances: (1) prompt pain relief while titrating a first-line drug; (2) treatment of episodic exacerbations of severe pain; [&] (3) treatment of neuropathic cancer pain. Tramadol is

a synthetic opioid affecting the central nervous system. The immediate release formulation is recommended at a dose of 50 to 100mg PO every 4 to 6 hours (not to exceed 400mg/day). This dose is recommended after titrating patients up from 100mg/day, with dosing being increased every 3 days as tolerated. For patients in need of immediate pain relief, which outweighs the risk of non-tolerability the initial starting dose, may be 50mg to 100mg every 4 to 6 hours (max 400mg/day). Ultram ER<sup>®</sup>: Patient currently not on immediate release tramadol should be started at a dose of 100mg once daily. The dose should be titrated upwards by 100mg increments if needed (Max dose 300mg/day). Patients currently on immediate release tramadol, calculate the 24-hour dose of IR and initiate a total daily dose of ER rounded to the next lowest 100mg increment (Max dose 300mg/day). Not recommended as a first-line therapy for osteoarthritis. Short-term use: Recommended on a trial basis for short-term use after there has been evidence of failure of first-line non-pharmacologic and medication options (such as acetaminophen or NSAIDs) and when there is evidence of moderate to severe pain. Also recommended for a trial if there is evidence of contraindications for use of first-line medications. Weak opioids should be considered at initiation of treatment with this class of drugs (such as Tramadol, Tramadol/acetaminophen, hydrocodone and codeine), and stronger opioids are only recommended for treatment of severe pain under exceptional circumstances (oxycodone, oxycodone, hydromorphone, fentanyl, morphine sulfate). Benefits of opioids are limited by frequent side effects (including nausea, constipation, dizziness, somnolence and vomiting). (Stitik, 2006) (Avouac, 2007) (Zhang, 2008). In this case, Tramadol was used for over a year with no documentation of pain improvement or recent scales in therapeutic response. Based on the above, it is not medically necessary.