

<b>Case Number:</b>	CM14-0174406		
<b>Date Assigned:</b>	10/28/2014	<b>Date of Injury:</b>	01/30/2002
<b>Decision Date:</b>	12/04/2014	<b>UR Denial Date:</b>	10/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/21/2014

### 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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This is a 67 year old patient with date of injury 1/30/02. Medical records indicate the patient is undergoing treatment for cervical degenerative disk disease with severe spinal stenosis and lumbar degenerative disk disease L4-5, L5-S1 with associated lumbar spinal stenosis. Subjective complaints include persistent cervical pain with radiation into the bilateral para scapular regions. Constant, mild pain in the low back with radiation to bilateral gluteal regions rated a 4-5/10. Pain worsened with prolonged sitting, standing and repetitive bending. Objective complaints include decreased range of motion lumbar and cervical spine, lumbar focal tenderness L3-4, L4-5, L5-S1, right worse than left, pain posterior spinous process and para vertebral muscles, forward flexion of his hands to about his mid-femur so he forward flexes 20 degrees, extension is 5 with pain in right gluteal region. Lateral bending is 5 to the right and 10 to the left with pain in his right gluteal region and posterior. Treatment has consisted of epidural injection 10/2014, Ibuprofen, Tramadol, Medrol dosepak. Physical therapy 2 x per week x 6 weeks with goals met and discharged to home exercise program. The utilization review determination was rendered on 10/7/14 recommending non-certification of decision for Tramadol 50mg #180 and twelve (12) physical therapy sessions for the lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol 50mg, #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management, Opioids Page(s): 94-95.

**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:** Ultram is the brand name version of tramadol, which is classified as 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. The original utilization review recommended weaning and modified the request, which is appropriate. As such, the request for Tramadol 50mg, #180 is not medically necessary.

**Twelve (12) physical therapy sessions for the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Physical Therapy

**Decision rationale:** California MTUS guidelines refer to physical medicine guidelines for physical therapy and recommends as follows: "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG quantifies its recommendations with 10 visits over 8 weeks for lumbar sprains/strains and 9 visits over 8 weeks for unspecified backache/lumbago. ODG further states that a "six-visit clinical trial" of physical therapy with documented objective and subjective improvements should occur initially before additional sessions are to be warranted. Medical records indicate the patient has had an unknown number of previous physical therapy visits and should have been educated on a home exercise program. Six clinical visits is a reasonable number for a "flare" and the utilization reviewer modified the request. As such, the request for Twelve (12) physical therapy sessions for the lumbar spine is not medically necessary.

