

<b>Case Number:</b>	CM14-0193192		
<b>Date Assigned:</b>	12/01/2014	<b>Date of Injury:</b>	02/13/2012
<b>Decision Date:</b>	01/14/2015	<b>UR Denial Date:</b>	11/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2014

### 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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 patient is a 49-year-old woman who sustained a work-related injury on February 13, 2012. Subsequently, the patient developed chronic low back pain. X-rays of the lumbar spine done on September 29, 2014 showed loss of the lumbar lordosis. There was a transitional S1 vertebra. MRI of the lumbar spine done on April 27, 2012 showed degenerative disc disease at the L4/L5 level with compression at the left L4-5 neural foramen, left paracentral L5/S1 disc with caudal extension and compressing the left S1 nerve root, transitional S1 vertebra with an anomalous articulation between the left S1 and transverse process and the adjacent sacral ala. Prior treatments included: pain medications, muscle relaxants, anti-inflammatories, physical therapy, and epidural steroid injection (on March 27, 2014), with minimal relief. According to a medical evaluation dated September 29, 2014, the patient complained of low back pain. She described the pain as moderate-to-severe in intensity. The pain was 7/10 at worst and 5/10 at best. She described the pain as a sharp pain, which was present on a constant basis. The patient had pain radiating to the left buttock and left leg down to the level of her left calf. In addition, she complained of pain on the undersurface of both feet. This pain was present first thing in the morning. She also complained of occasional pain in her mid and upper back and on the posterior aspect of the left shoulder. This pain was intermittent in nature. The patient admitted to being depressed and attributed her depression to her chronic low back pain. Physical examination revealed no sensory deficit in the lower extremities. Specifically, no sensory deficit in the S1 or L5 nerve root distributions in both legs. No peripheral weakness, no small muscle wasting. Knee jerks bilaterally, ankle jerks bilaterally, Babinski reflexes downgoing bilaterally. The patient was able to get up on her heels and her toes and take a few steps. There was vague tenderness in the lumbar paraspinal muscles bilaterally. With forward flexion, she brought her fingertips down to about the lower tibial area. The lateral bending, extension, and rotation were all within normal

limits and pain-free. She had good motion in the cervical spine without pain. She had mild tenderness in the thoracic paraspinal muscles bilaterally. There was no bony tenderness. Shoulder motion was within normal limits bilaterally with normal strength in all directions. She had normal reflexes in the upper extremities. Straight leg raising on the left was to 80 degrees without significant radicular pain. Straight leg raising on the right was to 90 degrees. She was 5/5 muscle strength in all major muscle groups in the lower extremities. There were no sensory deficits in the lower extremities. Knee jerks and ankle jerks were bilaterally. She had tenderness to palpation of the plantar aspect of both heels anteriorly at the site of the plantar fascial insertion. She had pain in this area with passive extension of the toes with the ankle in an extended position. The patient was diagnosed with lumbosacral sprain/strain, degenerative disc disease L4-5, lumbar disc herniation L5-S1, left lower extremity radiculopathy, chronic pain, and depression. The provider requested authorization for Tramadol.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Tramadol 50mg #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** According to MTUS guidelines, Ultram (Tramadol) is a synthetic opioid indicated for the pain management but not recommended as a first line oral analgesic. In addition and according to MTUS guidelines, ongoing use of opioids should follow specific rules: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy.(b) The lowest possible dose should be prescribed to improve pain and function.(c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework).Although, Tramadol may be needed to help with the patient pain, there is no clear evidence of objective and recent functional and pain improvement from its previous use. There is no clear documentation of the efficacy/safety of previous use of tramadol. There is no recent evidence of objective monitoring of compliance of the patient with her medications. Therefore, the prescription of Tramadol 50 mg is not medically necessary.