

<b>Case Number:</b>	CM15-0030443		
<b>Date Assigned:</b>	02/24/2015	<b>Date of Injury:</b>	12/18/2001
<b>Decision Date:</b>	04/02/2015	<b>UR Denial Date:</b>	02/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/18/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Indiana

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 54 year old male, who sustained an industrial injury on 12/18/2001. He has reported back pain. The diagnoses have included lumbago; myalgia and myositis, unspecified; and chronic pain syndrome. Treatment to date has included medications, physical therapy, and home exercise program. Medications have included Ultram, Valium, and Zanaflex. An evaluation with a treating provider, dated 01/05/2015, documented the injured worker to report back pain. The treating physician noted the injured worker to ambulate with a front wheeled walker. The treatment plan had included continuation of prescription medications, weight loss program, and restart home exercise program. Request is being made for a prescription for Ultram; and functional restoration program. On 02/03/2015 Utilization Review noncertified a prescription for Ultram 50 mg #90; and a prescription for Functional restoration program. The CA MTUS was cited. On 02/12/2015, the injured worker submitted an application for IMR for review of a prescription for Ultram 50 mg #90; and a prescription for Functional restoration program.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultram 50mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ultram (Tramadol).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. 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. As such, the request for Ultram is not medically necessary.

**Functional restoration program:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Program, Detoxification, Functional Restoration Programs Page(s): 30-49.

**Decision rationale:** MTUS states regarding the general use of multidisciplinary pain management programs: (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; (6) Negative predictors of success above have been addressed. The current request is for a functional restoration program evaluation. While the guidelines address adequacy of entry into a program, a few criteria are important to note prior to an evaluation. The treating physician notes that the patient has failed initial surgical attempts and is currently not a surgical candidate, which would support an evaluation for entry into a program. However, the treating physician does not adequately document a significant loss of ability to function due to chronic pain. Subject pain is documented, but medical records related to the request for the functional restoration program evaluation do not detail what abilities is loss specifically due to pain. As such, the request for Functional Restoration Program Evaluation is not medically necessary at this time.

