

<b>Case Number:</b>	CM14-0012687		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	02/11/2009
<b>Decision Date:</b>	07/10/2014	<b>UR Denial Date:</b>	01/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/31/2014

### 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 Physical Medicine and 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 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 injured worker is a 64-year-old with a reported injury date of January 11, 2009; the mechanism of injury was not provided. The injured worker's diagnoses include left knee intra-articular mechanical pain, status post osteotomy and arthroscopy, status post right knee removal of painful hardware, and possible depression. The clinical note dated December 16, 2013 noted that the injured worker underwent removal of hardware from his tibia on the right side 4 weeks ago. It was noted that the injured worker was currently taking medication which was helping. On physical examination of the right lower extremity, it was noted that the incision was well healed, there was no erythema or drainage. It was also noted that there was no change in his lower extremity sensory examination. Additionally, it noted that the injured worker could flex and extend his toes normally. The treatment plan included x-rays of the right lower extremity that will be obtained on the return visit, a prescription of Voltaren gel 2% as a topical agent to treat his pain, and tramadol 150 mg #60 for pain. The Request for Authorization for tramadol ER and Voltaren gel 2% was submitted on December 16, 2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TRAMADOL ER 150 MG, #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
CENTRAL ACTING ANALGESICS Page(s): 75.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that tramadol may be recommended for chronic pain; however, is not recommended as a first line oral analgesic. The guidelines also state that ongoing management of pain relief with opioids must include ongoing review and documentation of adequate pain relief, functional status, appropriate medication use, and side effects. This includes a pain assessment that includes current pain, the least reported pain over the period since the last assessment, average pain, intensity of pain after taking the opioid, how long it takes for pain relief, and how long pain relief lasts. There is a lack of adequate evidence provided within the documentation that this requested medication has provided an adequate therapeutic response. Additionally, it is unknown how long the injured worker has currently been prescribed this medication. Furthermore, there is no evidence of screening for possible side effects and/or appropriate drug use. The request for Tramadol ER 150mg, sixty count, is not medically necessary or appropriate.

**VOLTAREN GEL 2% WITH 3 REFILLS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that Voltaren gel 1% may be recommended for relief of osteoarthritis pain in joints that lend themselves to topical treatment to include ankle, elbow, foot, hand, knee, and wrist. This request remains unclear as the request is for Voltaren gel 2%; the guidelines only recommend Voltaren gel 1%. Additionally, a request for three refills is considered excessive as it doesn't allow for adequate screening of efficacy. Furthermore, it remains unclear, based on the documentation available, how long the injured worker has currently been prescribed this medication and if it has provided a therapeutic benefit. The request for Voltaren gel 2% with three refills is not medically necessary or appropriate.

**1 X-RAY OF THE RIGHT LOWER EXTREMITY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

**Decision rationale:** The American College of Occupational and Environmental Medicine Guidelines state that the clinical parameters for ordering x-rays includes joint effusion within 24 hours of direct blow or fall, palpable tenderness over the femoral head or patella, inability to walk (four steps) or bear weight immediately or within a week of the trauma, or an inability to flex knee to 90 degrees. There is a lack of objective clinical findings within the available

documentation that would benefit from an x-ray of the lower extremity. Additionally, there is a lack of rationale provided within the available documentation. The request for one x-ray of the right lower extremities is not medically necessary or appropriate.