

<b>Case Number:</b>	CM15-0216257		
<b>Date Assigned:</b>	11/05/2015	<b>Date of Injury:</b>	08/11/2007
<b>Decision Date:</b>	12/23/2015	<b>UR Denial Date:</b>	09/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/27/2015

### 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: California, North Carolina

Certification(s)/Specialty: Family Practice

### 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 69-year-old male with a date of injury on 08-11-2007. The injured worker is undergoing treatment for cervical degenerative disc, synovitis, bursitis of the shoulder and cervical radiculopathy. A physician progress note dated 08-20-2015 documents the injured worker still has daily pain in the left side of his neck and shoulder. There is focal tenderness in the subacromial space in the left shoulder. Impingement test is mildly positive. Motor and sensory exam was normal. He has full range of motion of his neck. Under ultrasound guidance, the left shoulder was injected. There appeared to be some rotator cuff damage. The physician stated "I believe as long as we can provide this gentleman with a reasonable quality of life, the medication is a better approach than further operative intervention." Tramadol and Naproxen have proven to be helpful. "Without the medication the patient has a Visual Analog Scale score of 69, with the current regimen of medications the patient's function has dramatically improved and the Visual Analog Scale score is 17." Treatment to date has included diagnostic studies, medications, cervical epidural injection, physical therapy, status post left rotator cuff repair on 10-27-2015. Magnetic Resonance Imaging of the left shoulder done on 08-21-2014 revealed a full thickness rotator cuff tear. The Request for Authorization dated 08-20-2015 includes Tramadol (since at least 02020-2015), Ultrasonic guidance, left shoulder subacromial space injection along with a glenohumeral joint injection, and Voltaren gel. On 09-22-2015 Utilization Review non-certified the request for Retrospective Tramadol/Acetaminophen 37.5/325mg #120-1 months maintenance (dispensed 8/20/15), Retrospective Ultrasound, ultrasonic guidance, left shoulder subacromial space injection along with the glenohumeral joint with 2 cc of 0.25% Marcaine solution, 2 cc of Decadron with 2 cc (60mg) of Toradol (DOS 8/20/15), and Voltaren gel 1% 100gm tube #5 (prescribed 8/20/15).

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Retrospective Tramadol/Acetaminophen 37.5/325mg #120/1 months maintenance (dispensed 8/20/15): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for neuropathic pain. Decision based on Non-MTUS Citation ACOEM, Chapter 3, Treatment, Initial Approaches to Treatment page 47-48, Official Disability Guidelines (ODG), Pain Chapter, Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

**Decision rationale:** Tramadol is a centrally acting synthetic opioid being used in this claimant for chronic shoulder pain. Authorization was previously requested with the recommendation for weaning the patient off Tramadol. Adequate time has elapsed to accomplish the weaning process. Tramadol is only recommended for short-term use. The patient has been provided the Tramadol in excess of the recommendations for use. There is also minimal evidence of functional improvement, improved ability to perform ADLs or improvement in work status. Therefore, the request is not medically necessary or appropriate.

### **Voltaren gel 1% 100gm tube #5 (prescribed 8/20/15): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** The request is for Voltaren gel, a topical NSAID. CA MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. There is little to no research to support the use of many of these agents. Voltaren gel is only indicated for up to 2 weeks of use during the acute phase of treatment. In this case, the patient is well-beyond the acute phase and there is no documentation of flare-ups. In addition, topical NSAIDs are not indicated unless there is an intolerance to oral NSAIDs, which is not the case in this patient. Further, Voltaren gel is not indicated for the shoulder joint, as is the case with this patient.

### **Retrospective Ultrasound, ultrasonic guidance, left shoulder subacromial space injection along with the glenohumeral joint with 2 cc of 0.25% Marcaine solution, 2 cc of Decadron with 2 cc (60mg) of Toradol (DOS 8/20/15): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004.  
Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter,  
Steroid injections.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS.  
Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder chapter  
(steroid injections).

**Decision rationale:** CA MTUS/ACOEM does not specifically address this request. ODG states that corticosteroid injections may be recommended if there is a flare-up of the patient's condition. However, there is no evidence of a flare-up of shoulder pain in this case. The use of ultrasound guidance for the injection is not supported by guidelines. There is no evidence of improved outcome of injections to the shoulder with ultrasound guidance; therefore, it is not medically necessary or appropriate.