

<b>Case Number:</b>	CM15-0082023		
<b>Date Assigned:</b>	05/04/2015	<b>Date of Injury:</b>	02/05/2010
<b>Decision Date:</b>	06/02/2015	<b>UR Denial Date:</b>	04/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/29/2015

### 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 63 year old female, who sustained an industrial injury on 2/5/10. Initial complaints were not noted. The injured worker was diagnosed as having non-traumatic rupture of other tendons of foot and ankle; plantar fascial fibromatosis bilateral; disorders of muscle, ligament, and fascia; other fibromatosis; localized primary osteoarthritis ankle and/or foot; osteoarthrosis localized primary ankle and foot; post-traumatic stress disorder; adjustment reaction other specified adjustment reactions; knee pain, pain in joint lower leg; degenerative lumbar/lumbosacral intervertebral disc; neuropathic pain; neuralgia, neuritis and radiculitis unspecified; degeneration of lumbosacral intervertebral disc. Treatment to date has included physical therapy; medications. Currently, the PR-2 notes dated 4/8/15 indicated the injured worker was seen in this office on this date as a follow-up for low back and bilateral lower extremity pain. There are no new complaints and additional physical therapy has been authorized, but she has not completed these sessions.. Objective findings are the injured worker is in no acute distress. She has a slow and wide based gait and walks with a cane. Sensation is intact except absent pinprick sensation in the dermal distribution of the bilateral lower extremities. She presents for follow-up of bilateral foot pain and low back pain and symptoms continue to be significant and have not been in remission for the last 3-6 months. She continues to rely on medications in order to perform her activities of daily living and maintain functionality. The provider's treatment plan includes Tramadol 50mg # 270 and Voltaren Gel 1% Topical Gel (GM) #300.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol 50mg # 270:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing management Page(s): 78-80.

**Decision rationale:** Tramadol 50mg # 270 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that a satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The MTUS does not support ongoing opioid use without improvement in function or pain. The documentation reveals that the patient has been on long term opioids without significant evidence of functional improvement and with persistent significant pain therefore the request for continued Tramadol is not medically necessary.

**Voltaren Gel 1% Topical Gel (GM) Qty 300:** Upheld

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

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

**Decision rationale:** Voltaren Gel 1% Topical Gel (GM) Qty 300 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS recommends topical NSAIDs for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Voltaren Gel 1% (diclofenac) is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. The documentation indicates that the patient has been using Voltaren Gel for longer than the 12 week period without significant functional improvement therefore the request for Voltaren Gel is not medically necessary.