

<b>Case Number:</b>	CM14-0118127		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	05/26/2010
<b>Decision Date:</b>	10/06/2014	<b>UR Denial Date:</b>	07/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/25/2014

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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:

This is a 72-year-old male with a 5/26/10 date of injury. The mechanism of injury was not noted. According to a progress report dated 7/23/14, the patient complained of persistent cervical spine, lumbar spine, left shoulder, left wrist, and left hand pain. He rated his pain at 7/10. Ultram improved his pain level from 7/10 to 4-6/10. The patient was not currently working. Objective findings: tenderness to palpation of cervical spine, right shoulder, left shoulder, and lumbar spine; full ROM of cervical spine and lumbar spine, limited ROM of bilateral shoulders. Diagnostic impression: status post right shoulder rotator cuff repair. Treatment to date: medication management, activity modification. A UR decision dated 7/22/14 denied the requests for Tramadol/APAP, Voltaren gel, and Ultram. Regarding Tramadol/APAP and Ultram, this medication has not been adequately documented to support medical necessity at this time. The guidelines do not support long term utilization of the narcotic analgesics. Regarding Voltaren gel, there are insufficient large-scale, randomized, controlled references showing the safety and efficacy of the requested compound prescription in this claimant's clinical scenario.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol/APAP (37.5/325mg) #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Narcotic Analgesics Page(s): 91.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The provider is also requesting Ultram, which contains the same ingredient as this request, Tramadol. Guidelines do not support the use of 2 short-acting opioid medications containing the same ingredient. In addition, there is no documentation of lack of aberrant behavior or adverse side effects, an opioid pain contract, urine drug screen, or CURES monitoring. Therefore, the request for Tramadol/APAP (37.5/325mg) #60 was not medically necessary.

**Ultram (Tramadol) 50mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The provider is also requesting Tramadol/APAP 37.5/325mg, which contains the same ingredient as this request, Tramadol. Guidelines do not support the use of 2 short-acting opioid medications containing the same ingredient. In addition, there is no documentation of lack of aberrant behavior or adverse side effects, an opioid pain contract, urine drug screen, or CURES monitoring.

**Voltaren Gel #1000:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

**Decision rationale:** CA MTUS states that Voltaren Gel is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist); and has not been evaluated for treatment of the spine, hip or shoulder. There is no documentation that the patient has a diagnosis of osteoarthritis. In addition, there is no documentation of the area for which Voltaren gel is being applied. Guidelines do not support the use of Voltaren gel for back and shoulder pain. In addition, there is no documentation that the

patient is unable to tolerate an oral NSAID. In fact, it is noted that the patient is on multiple oral medications. Therefore, the request for Voltaren Gel #1000 was not medically necessary.