

<b>Case Number:</b>	CM15-0012047		
<b>Date Assigned:</b>	01/29/2015	<b>Date of Injury:</b>	05/20/2005
<b>Decision Date:</b>	03/23/2015	<b>UR Denial Date:</b>	01/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2015

### 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 51 year old female who sustained an industrial injury reported on 5/20/2008. She has reported right hand pain. The diagnoses have included dislocated proximal interphalangeal joint of the little finger on the left hand; right carpal tunnel; and chronic epicondylitis of the right elbow. Treatments to date have included consultations; diagnostic laboratory and imaging studies; pain diagram study of the right upper extremity; right carpal tunnel release surgery (7/23/10)-(unsuccessful); and medication management. The status classification for this injured worker (IW) was noted to be permanent and stationary. On 1/19/2015 Utilization Review (UR) modified, for medical necessity, the request, made on 1/12/2015, for Ultram 50mg #30 to #20 with no future refills; and non-certified, for medical necessity, the request for Voltaren gel 1% x 1 tube. The Medical Treatment Utilization Schedule, chronic pain treatment guidelines, synthetic opioid medication - ongoing management, topical analgesics, was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultram 50mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines The 4 A's ongoing monitoring Page(s): 74-97.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

**Decision rationale:** The patient was injured on 05/20/08 and presents with aching pain with some numbness in anatomical distribution from the shoulder to the fingers of the right hand. The request is for ULTRAM 50 MG #30. There is no RFA provided and the patient is permanent and stationary. There is no indication of when the patient began taking Ultram. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4 A's (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work, and duration of pain relief. The 12/31/14 report states that the patient has problems dressing herself, showering/ bathing without help, lifting/carrying, traveling, and sleeping. Although the treater provided a discussion regarding the patient's ADLs, not all 4 A's are addressed as required by MTUS guidelines. The treater does not provide any pain scales, nor are there any discussions provided on adverse behaviors/side effects. There is no opiate management issues discussed such as CURES report, pain contract, etc. No outcome measures are provided either as required by MTUS Guidelines. In addition, urine drug screen to monitor for medicine compliance are not addressed. The treating physician does not provide proper documentation that is required by MTUS Guidelines for continued opiate use. Therefore, the requested Ultram IS NOT medically necessary.

**Voltaren gel 1% 1 tube:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-112.

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

**Decision rationale:** The patient was injured on 05/20/08 and presents with aching pain with some numbness in anatomical distribution from the shoulder to the fingers of the right hand. The request is for VOLTAREN GEL 1% 1 TUBE to be applied to the right upper extremity. There is no RFA provided and the patient is permanent and stationary. There is no indication of when the patient began using Voltaren Gel. MTUS page 111 of the chronic pain section states the following regarding topical analgesics: "Largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents." Regarding topical NSAIDs, page 111-113 states, "Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended 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. Neuropathic pain: Not recommended as there is no evidence to support use." The patient is

diagnosed with probable continued carpal tunnel syndrome at the right wrist and with tendonitis at the right elbow and right shoulder. She has a positive Tinel's Wrist Tappign Test, a positive Phalen's Wrist Flexion Test, and a positive Cozen's Test. On the right shoulder, she has tendonitis with impingement syndrome of the rotator cuff of the right shoulder on raising the arm away from the side. Local tenderness is present at the rotator cuff and subacromial bursa. The 12/31/14 report, the only report provided, does not mention Voltaren's effectiveness in terms of pain and function. MTUS page 60 require recording of pain and function when medications are used for chronic pain. Due to lack of documentation, the requested Voltaren Gel IS NOT medically necessary.