

<b>Case Number:</b>	CM15-0114099		
<b>Date Assigned:</b>	06/22/2015	<b>Date of Injury:</b>	10/03/2002
<b>Decision Date:</b>	07/21/2015	<b>UR Denial Date:</b>	06/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2015

### 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: Preventive Medicine, Occupational 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 66-year-old female, who sustained an industrial injury on October 3, 2002. She reported back and knee pain after a slip and fall. The injured worker was diagnosed as having status post knee replacement, lumbar disc displacement without myelopathy, thoracic or lumbosacral neuritis or radiculitis, cervical radiculitis and myalgia and myositis. Treatment to date has included diagnostic studies, knee replacement, physical therapy, acupuncture, chiropractic care, epidural steroid injections of the low back, knee injections, medications and work restrictions. Currently, the injured worker complains of continued pain in the low back with left lower extremity pain and hip pain. The injured worker reported an industrial injury in 2002, resulting in the above noted pain. She was treated conservatively and surgically without complete resolution of the pain. Evaluation on May 21, 2015, revealed continued severe pain rated at a 10 on a 1-10 scale with 10 being the worse. She noted improvement following acupuncture treatments. She reported participating in a home exercise plan and requiring medications to remain functional. Medications were requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One container of Voltaren 1% gel with 2 refills: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Voltaren® Gel (diclofenac).

**Decision rationale:** According to the Official Disability Guidelines, Voltaren gel is not recommended as a first as a first-line treatment, and is recommended only for osteoarthritis after failure of oral NSAIDs, or contraindications to oral NSAIDs, or for patients who cannot swallow solid oral dosage forms, and after considering the increased risk profile with diclofenac, including topical formulations. Documentation in the medical record does not meet guideline criteria. One container of Voltaren 1% gel with 2 refills is not medically necessary.

**90 tablets of Ultram 37.5/325 mg with 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
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**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of Ultram, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 6 months. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of narcotic. The original reviewer modified the request to exclude all refills. 90 tablets of Ultram 37.5/325 mg with 1 refill is not medically necessary.