

<b>Case Number:</b>	CM14-0137696		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	02/22/2011
<b>Decision Date:</b>	10/02/2014	<b>UR Denial Date:</b>	08/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/25/2014

### 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 General Preventive Medicine, and is licensed to practice in Indiana. 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 employee is a 35 year old female with date of injury of 2/22/2011. A review of the medical records indicate that the patient is undergoing treatment for left foot and pernoeal tenosynovitis and subtalar impingement, compression of T7, T8, and T12, and chronic pain syndrome. Subjective complaints include frequent dull 5/10 pain in her foot and lower back. Objective findings include tenderness in the heal; decreased range of motion in left ankle to dorsal flexion and ankle plantar flexion; tenderness to palpation of paralumbar muscles over the T7-T12 vertebrae. Treatment has included ibuprofen, tramadol, surgery, physical therapy, and home exercise. The utilization review dated 8/5/2014 non-certified partially certified upright lumbar MRI and Voltaren Gel 1%.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Upright Lumbar MRI:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315. Decision based on Non-MTUS Citation This employee is a 35 year old female with date of injury of 2/22/2011. A review of the medical records indicate that the patient is undergoing treatment for left foot and pernoeal tenosynovitis and subtalar impingement,

compression of T7, T8, and T12, and chronic pain syndrome. Subjective complaints include frequent dull 5/10 pain in her foot and lower back. Objective findings include tenderness in the heel; decreased range of motion in left ankle to dorsal

**Decision rationale:** MTUS and ACOEM recommend MRI, in general, for low back pain when "cauda equine, tumor, infection, or fracture are strongly suspected and plain film radiographs are negative, MRI test of choice for patients with prior back surgery" ACOEM additionally recommends against MRI for low back pain "before 1 month in absence of red flags". ODG states, "Imaging is indicated only if they have severe progressive neurologic impairments or signs or symptoms indicating a serious or specific underlying condition, or if they are candidates for invasive interventions. Immediate imaging is recommended for patients with major risk factors for cancer, spinal infection, cauda equina syndrome, or severe or progressive neurologic deficits. Imaging after a trial of treatment is recommended for patients who have minor risk factors for cancer, inflammatory back disease, vertebral compression fracture, radiculopathy, or symptomatic spinal stenosis. Subsequent imaging should be based on new symptoms or changes in current symptoms." The medical notes provided did not document (physical exam, objective testing, or subjective complaints) any red flags, significant worsening in symptoms or other findings suggestive of the pathologies outlined in the above guidelines. As such, the request for Upright Lumbar MRI is not medically necessary.

**Voltaren Gel 1 %:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams

**Decision rationale:** MTUS and ODG recommends usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." MTUS specifically states for Voltaren Gel 1% (diclofenac) that it 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." Medical records do not indicate that the patient is being treated for osteoarthritis pain in the joints. Therefore, Voltaren Gel 1% is not medically necessary.