

<b>Case Number:</b>	CM14-0152703		
<b>Date Assigned:</b>	09/22/2014	<b>Date of Injury:</b>	01/28/2009
<b>Decision Date:</b>	10/23/2014	<b>UR Denial Date:</b>	08/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2014

### 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 Physical Medicine & Rehabilitation has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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:

The injured worker is a 51-year-old female with a reported date of injury on 01/28/2009. The mechanism of injury was a fall. The injured worker's diagnoses included lumbago and degeneration of the thoraco/lumbar intervertebral discs. The injured worker's past treatments included epidural steroid injections, pain medications, physical therapy, and trigger point injections. The injured worker's diagnostic testing included MRI performed on 07/06/2011 which revealed neural foraminal disc protrusion, facet hypertrophy at the L3-4 level, and bilateral foraminal narrowing at L4-5 and L5-S1. There was no relevant surgical history documented in the records. The subjective complaints on 07/07/2014 included pain in the lower back, bilateral hips, buttocks, and left lower extremity. The objective physical exam findings noted diffuse moderate tenderness to palpation over the lumbosacral region. There was significant point tenderness over the left lateral side of the L3-5 level. Negative straight leg raise bilateral was noted. Lumbar range of motion is decreased. The injured worker's medications included Norco, Neurontin, Thermacare, and Voltaren gel. The treatment plan was to continue with all medications. A request was received for Voltaren gel 4 grams and trigger point injections. The rationale for the request was not provided. The request for authorization form was dated 07/07/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren Gel 4 Grams:** 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): 111-112.

**Decision rationale:** The request for Voltaren gel 4 grams is not medically necessary. The California MTUS Guidelines state that Voltaren gel is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment. It has not been evaluated for treatment of the spine, hip or shoulder. The injured worker presents with chronic low back pain and hip pain. The use of Voltaren gel is not supported in the spine or the hip. As Voltaren is not indicated for the spine or the hip, the request is not supported by the guidelines. As such, the request is not medically necessary.

**Trigger Point Injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122.

**Decision rationale:** My rationale for why the requested treatment/service is or is not medically necessary: The request for trigger point injections is not medically necessary. The California MTUS Guidelines state trigger point injections with local anesthetic may be recommended for treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met, documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain, symptoms have persisted for more than 3 months, medical management therapy such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain, radiculopathy is not present in the exam or diagnostic imaging. The injured worker has chronic back pain. There was a lack of documentation in the notes of circumscribed trigger points with evidence upon palpation of twitch response as well as referred pain. There was a lack of documentation regarding how long the symptoms have lasted, and if medical management therapy such as ongoing stretching exercises, physical therapy, NSAIDs, and muscle relaxants have failed to control the pain. In the absence of the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.