

<b>Case Number:</b>	CM14-0047554		
<b>Date Assigned:</b>	06/27/2014	<b>Date of Injury:</b>	01/28/2012
<b>Decision Date:</b>	09/16/2014	<b>UR Denial Date:</b>	03/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/31/2014

### 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 and Rehabilitation has a subspecialty in Pain Medicine and is licensed to practice in California. 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 patient is a 46 year old male who sustained an industrial injury on 1/28/2012, resulting from a trip and fall. He is status post left knee arthroscopy with medial meniscectomy on 10/10/2012. He is noted to have past medical history significant for DM and hypertension, as well as previous injury as an infant child resulting in traumatic loss/amputation of toes 2-5 on left foot. Past medical treatment has included norco, vicodin, ultram, fexmid, sonata, dendracin lotion, voltaren gel, and acupuncture. A prior peer review on 3/26/2014 certified the prospective request for 1 consult with foot specialist. The prospective request for left knee brace was conditionally non-certified. The prospective requests for voltaren gel and pain management consult for lumbar ESI were non-certified. The patient does not utilize NSAIDs due to hypertension. The guidelines cited voltaren topical NSAID had the potential for worsening pre-existing hypertension. The pain management consultation for lumbar ESI was not indicated as the patient's pain complaints did not appear to be radicular, but more compensatory due to knee pain and altered gait, and there was not objective findings of radiculopathy. Lumbar MRI on 4/14/2012 provided the impressions: 1. Mild degenerative endplate changes in the lower lumbar spine with osteophyte formation and posterior bony spurring with multilevel degeneration disc disease and degenerative facet hypertrophy. 2. At L4-5, broad-based disc protrusion measuring approximately 5 mm with mild facet hypertrophy but no spinal canal or neural foraminal stenosis. 3. At L5-S1, diffuse disc bulge measuring approximately 3 mm with mild facet hypertrophy. 4. No central spinal canal stenosis or neural foraminal stenosis at any level of the lumbar spine. The patient had an initial podiatric consultation on 6/3/2014 for his left foot/ankle complaint. Physical examination reveals 2+/4 bilaterally and symmetrical Achilles and patellar reflexes, normal gait, intact sensation, no evidence of RSDS, 5/5 motor strength of ankle/foot bilaterally. There is enlargement of the medial eminence of the left foot, arthritic change of the

left foot with ROM of 1st metatarsophalangeal joint, pain with dorsi/plantar-flexion of the 1st MTP joint, difficulty toe walk and with palpation of the region. Diagnoses are amputation of 2-5 toes due to monkey attack as a child; hallux valgus deformity of the left foot; and DJD of the first MTP joint. Recommendation involves surgical intervention to the left foot metatarsophalangeal joint under fluoroscopy. According to the most recent PR-2 dated 7/2/2014, the patient continues to experience lower back pain radiating to the left lower extremity. The left knee remains painful with occasional giving way. He continues to experience left foot and ankle pain. Surgery is recommended by [REDACTED]. Pain is rated 5-6/10 with medications; 7-8/10 without medications. He is able to perform ADLs and work. Examination of the left foot reveals prior amputation of second through fifth toes, sharp tenderness over the plantar surface of the 1st metatarsophalangeal joint. Examination of the lumbar spine reveals tenderness to palpation with over the bilateral paraspinal muscular with spasm, and over the bilateral SI joints. SLR elicits increased low back pain and left lower extremity radicular pain. Lumbar ROM is restricted. Diagnoses are s/p left knee arthroscopy 10/12/2012; x-ray dated 11/5/2013 revealing degenerative changes at medial joint line; left ankle sprain; left great toe sprain and metatarsalgia with history of childhood traumatic amputation of the left second to fifth toes; lumbar spine musculoligamentous sprain/strain with a 5 mm disc protrusion at L4-5 with mild degenerative facet hypertrophy and 3 mm disc bulge at L5-S1 with mild hypertrophy with multilevel degenerative disc disease, per MRI scan dated 4/4/2012; x-rays of left toe dated 1/30/2014 revealing osteoarthritis at metatarsophalangeal joint of the first toe. Treatment plan: await response for request left foot surgery per [REDACTED] podiatric consult, request report, and continue use of supplied foot pillows; continue pain management for lumbar spine; follow up in 4-5 weeks. Current medications continue as Norco 5/325 mg, voltaren gel, fexmid, and sonata.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**1 prescription for Voltaren gel:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical non-steroidal anti-inflammatory drug (NSAID).

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

**Decision rationale:** According to the CA MTUS guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Regarding topical NSAIDs, the efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. Voltaren Gel 1% (diclofenac) is an FDA approved topical analgesic agent that is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). The guidelines indicate the topical product is efficacious in only short-term use. The medical records document use of voltaren gel. However, there is no evidence of objective functional improvement demonstrated with use. The patient continues opioids and

muscle relaxants, and minimal/ negligible reduction in pain with medication use is documented. The reduction in pain and improvement function resulting from Voltaren gel use is not apparent. The medical necessity of Voltaren gel has not been established. The request is non-certified.

**1 pain management consult for lumbar epidural steroid injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of epidural steroid injections Page(s): 56.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7 - Independent Medical Examinations And Consultations, pages 503.

**Decision rationale:** According to the CA MTUS/ACOEM guidelines, the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. The guidelines also state radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing. The medical records document the patient has normal and intact sensation, 5/5 motor strength, and 2+/4 reflexes of the bilateral lower extremities. In addition, the patient's 12/10/2012 lumbar MRI revealed no spinal canal or neural foraminal stenosis; which is consistent with the absence of radiculopathy on physical examination. The patient has findings consistent with lumbar strain, left great toe MTP OA, and persistent left knee pain s/p arthroscopy; however, the medical records do not establish the patient has lumbar radiculopathy. Consequently, pain management consult for lumbar ESI is not medically indicated. Therefore the request is not medically necessary.