

<b>Case Number:</b>	CM14-0207985		
<b>Date Assigned:</b>	12/19/2014	<b>Date of Injury:</b>	01/23/2008
<b>Decision Date:</b>	02/13/2015	<b>UR Denial Date:</b>	11/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/12/2014

### 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 Rehab, has a subspecialty in Neuromuscular Medicine, and is licensed to practice in Maryland. 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 67 year old female with a work injury dated 1/23/08. The diagnoses include a myoligamentous lumbar spine strain/sprain; multilevel lumbar spondylosis; status-post right total knee arthroplasty, July 9, 2014; status-post left total knee arthroplasty, November 6, 2013. Under consideration are requests for 10 physical therapy visits for the lumbar spine and for Voltaren Gel. There is an 11/5/14 primary treating physician progress report that states that the patient has back and right knee pain. The patient complains of increased low back pain and weakness in the left hip. She has continued right knee pain and weakness. The left knee is doing well. The patient describes her pain back as an intermittent aching pain. Her bilateral knee pain is described as occasional dull, aching pain. She also has pain in the shoulder with activity. The patient has increased discomfort with prolonged sitting, prolonged walking, bending and pushing. She has alleviation in her symptoms with rest, therapy, and pain medication. She also complains of numbness and tingling in the left leg at times and the right side of the knee, along with weakness of her back, shoulder and right knee. The patient requests a prescription for Norco 5 mg for daytime use and 10 mg for sleeping. On exam the patient walks with a normal gait and arm swing without assisted devices. Lumbar Spine reveals tenderness to palpation of the lumbar paraspinal region. Strength is 5/5 of the lower extremities, except with hip flexion which is 4/5. Right Knee reveals a range of motion is 0-100. Strength is 4+ / 5 with extension and flexion. She has a stable knee. There is normal sensation. There is a request for authorization for ten sessions of physical therapy, two times a week for five weeks, for the lumbar spine. If the patient has not improvement, and giving the weakness of right hip flexion, consideration will be given for an updated MRI scan of the lumbar spine. The patient was provided with Voltaren Gel, as well as prescriptions for Norco 5/325 mg one tablet q8hr #90 and Norco 10/325 mg one tablet hs #30, and authorization is requested.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**10 Physical therapy visits for the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99.

**Decision rationale:** The request for 10 physical therapy visits for the lumbar spine is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. Although the guidelines recommend up to 10 visits for this patient's low back condition, the documentation is not clear on how many prior therapy visits the patient has had as well as the outcome of these visits. Without clarification of this information, the request for 10 physical therapy visits for the lumbar spine is not medically necessary.

**Voltaren gel:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

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

**Decision rationale:** Voltaren gel is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. Voltaren gel 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. The documentation indicates that the patient has lumbar pain. The documentation indicates that the patient has had a knee replacement bilaterally. The guidelines do not recommend this gel for spine pain. Additionally, the request does not state a quantity. The guidelines also state that the maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The request does not indicate a strength or frequency of application as well. For all of these reasons, the request for Voltaren gel is not medically necessary.