

Case Number:	CM15-0109011		
Date Assigned:	06/15/2015	Date of Injury:	11/08/2013
Decision Date:	07/15/2015	UR Denial Date:	05/20/2015
Priority:	Standard	Application Received:	06/05/2015

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: Physical Medicine & Rehabilitation, Pain Management

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 64-year-old male who sustained an industrial injury on 11/8/13 in which the mechanism of injury was a slip and fall. He reports left shoulder pain, low back pain radiating into the right hip and right lower extremity to above the ankle level with occasional tingling and numbness down the right lower extremity to above the ankle level and right knee pain. He rates the left shoulder pain as 4/10, the low back pain as 6-7/10 and the right knee pain as 6/10. Diagnoses are joint pain-shoulder, adhesive capsulitis -shoulder, lumbago, lumbar/lumbosacral disc degeneration, joint pain left leg, knee degenerative osteoarthritis, pain in limb, status post right knee arthroscopic surgery-3/14/14 and status post left shoulder surgery-8/2014. Prior treatment includes at least 12 physical therapy visits, home exercise program, Ibuprofen and heat/ice as needed. A physician evaluation dated 4/28/15 reports limitations with activities of daily living as 3/5 for dressing himself, 3/5 difficulty with physical activities such as standing, sitting, reclining, walking, grasping, gripping and lifting, and 2/5 difficulty with manipulating small items. He reports sleep is not restful. The lack of sleep is secondary to pain. An examination dated 4/28/15 notes normal gait, supine straight leg raise as 70 degrees on the right and 80 degrees on the left. The right knee demonstrates motion is 0-135 degrees with medial joint line and pes tenderness, subpatellar crepitation on range of motion, pivot shift positive on the right and negative on the left, anterior drawer sign is grade II on the right and Lachman test is grade II on the right. There is slight tenderness of the left shoulder. Roentgenograms of the lumbar spine, right hip, left shoulder and right knee were done on 4/28/15. Work status documented 4/28/15 is reported as temporarily totally disabled for 6 weeks.

The treatment plan is home heat/ice as needed, topical analgesic ointment application as needed, stretch and strength home exercise program; abdominal core exercises, over the counter analgesic/anti-inflammatory medications as needed, updated magnetic resonance-arthrogram of the right knee to evaluate for anterior cruciate ligament and meniscal tear/re-tear, physical therapy for the right knee post anterior cruciate ligament quad rehab and for lumbar spine interspinous fusion system, ultrasound, with rehab and Williams/McKenzie exercises twice weekly for 6 weeks, Voltaren Gel 1% twice daily- 3 tubes, Mobic 15 mg once daily, right knee elastic support as needed, lumbar corset as needed, and possible Supartz injections (3) for the right knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren gel 1% 3 tubes: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009) Page(s): 111-112 of 127.

Decision rationale: Regarding the request for Voltaren gel, guidelines state that topical NSAIDs are recommended for short-term use. Oral NSAIDs contain significantly more guideline support, provided there are no contraindications to the use of oral NSAIDs. Within the documentation available for review, there is no indication that the patient has obtained any specific analgesic effect (in terms of percent reduction in pain, or reduced NRS) or specific objective functional improvement from the use of Voltaren gel. Additionally, there is no documentation that the patient would be unable to tolerate oral NSAIDs, which would be preferred, or that the Voltaren is for short-term use, as recommended by guidelines. In the absence of clarity regarding those issues, the currently requested Voltaren gel is not medically necessary.