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| Case Number: | CM15-0221658 | | |
| Date Assigned: | 11/17/2015 | Date of Injury: | 08/24/2012 |
| Decision Date: | 12/24/2015 | UR Denial Date: | 11/03/2015 |
| Priority: | Standard | Application Received: | 11/11/2015 |

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, Indiana, New York
 Certification(s)/Specialty: Internal Medicine

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 63 year old male who sustained an industrial injury on 08-24-2012. A review of the medical records indicated that the injured worker is undergoing treatment for cervical facet arthropathy, left cervical radiculopathy and headaches. According to the treating physician's progress report on 08-20-2015, the injured worker continues to experience constant neck pain with numbness, tingling, and headaches rated at 10 out of 10 on the pain scale. Visual inspection of the cervical spine noted a well-preserved cervical posture with no splinting and no surgical scars visible. Examination demonstrated tenderness and muscle spasm bilaterally over the trapezius muscles. Range of motion was normal with negative Spurling's bilaterally. Sensation was decreased in the ulnar aspect of both forearms, greater on the left side. Motor strength of the supraspinatus, infraspinatus, elbow extensors, elbow pronators and elbow supinator and wrist flexors and abductors were 5 out of 5 bilaterally. Deep tendon reflexes could not be obtained bilaterally. Vascular status was intact. Phalen's, Tinel's and Finklestein's test were negative bilaterally. Prior treatments have included diagnostic testing, chiropractic therapy, acupuncture therapy, physical therapy, cervical transforaminal epidural steroid injection, trigger point injection to the trapezius and medications. Current medication was listed as Ibuprofen. Treatment plan consists of electrodiagnostic studies, neurosurgical consultation and the current request for a functional restoration program (FRP) and Voltaren gel. On 11-03-2015 the Utilization Review determined the requests for a functional restoration program (FRP) and Voltaren gel were not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Gel: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Topical analgesics.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Voltaren (Diclofenac) gel is not medically necessary. Topical analgesics are largely experimental with few controlled trials to determine efficacy and safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The only available FDA approved topical analgesic is diclofenac. However, diclofenac gel is indicated for relief of osteoarthritis pain in the joint that lends itself to topical treatment (ankle, elbow, foot, hand, knee and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. In this case, the injured worker's working diagnoses are headaches; cervical facet arthropathy; and left cervical radiculitis. Date of injury is August 24, 2012. Request for authorization is October 30, 2015. The most recent progress note in the medical record is dated August 20, 2015. There is no contemporaneous clinical documentation on or about the date of request for authorization October 30, 2015. According to the most recent progress note dated August 20, 2015, subjective complaints are neck pain and headache. Medications include ibuprofen 800 mg PO TID. The injured worker was being treated for prostate cancer and is out of work for treatment of the prostate cancer. Objectively, there is tenderness to palpation over the bilateral trapezius muscles. Range of motion is normal and there is decreased sensation over the ulnar forearm. The documentation in the treatment plan indicates the injured worker is being treated with Botox for headache, Topamax dosing is increased and the treating provider ordering physical therapy to the neck. There is a neurosurgical consultation pending. There is no documentation of a functional restoration program in the treatment plan. There is no documentation of a topical analgesic request. As noted above, there is no contemporaneous documentation on about the date of request for authorization October 30, 2015. Voltaren gel is indicated for relief of osteoarthritis pain in the joint that lends itself to topical treatment (ankle, elbow, foot, hand, knee and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. As noted above, there is no clinical discussion, indication or rationale for Voltaren gel. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines and no contemporaneous clinical documentation on or about the date of request for authorization, Voltaren (Diclofenac) gel is not medically necessary.

Functional restoration program: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Chronic pain programs (functional restoration programs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional restoration programs (FRPs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Functional restoration programs (FRPs).

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, functional restoration program is not medically necessary. A functional restoration program (FRP) is recommended when there is access to programs with proven successful outcomes (decreased pain and medication use, improve function and return to work, decreased utilization of the healthcare system. The criteria for general use of multidisciplinary pain management programs include, but are not limited to, the injured worker has a chronic pain syndrome; there is evidence of continued use of prescription pain medications; previous methods of treating chronic pain have been unsuccessful; an adequate and thorough multidisciplinary evaluation has been made; once an evaluation is completed a treatment plan should be presented with specifics for treatment of identified problems and outcomes that will be followed; there should be documentation the patient has motivation to change and is willing to change the medication regimen; this should be some documentation the patient is aware that successful treatment may change compensation and/or other secondary gains; if a program is planned for a patient that has been continuously disabled from work more than 24 months, the outcomes for necessity of use should be clearly identified as there is conflicting evidence that chronic pain programs provide return to work beyond this period; total treatment should not exceed four weeks (20 days or 160 hours) or the equivalent in part based sessions. If treatment duration in excess of four weeks is required, a clear rationale for the specified extension and reasonable goals to be achieved should be provided. The negative predictors of success include high levels of psychosocial distress, involvement in financial disputes, prevalence of opiate use and pretreatment levels of pain. In this case, the injured worker's working diagnoses are headaches; cervical facet arthropathy; and left cervical radiculitis. Date of injury is August 24, 2012. Request for authorization is October 30, 2015. The most recent progress note in the medical record is dated August 20, 2015. There is no contemporaneous clinical documentation on or about the date of request for authorization October 30, 2015. According to the most recent progress note dated August 20, 2015, subjective complaints are neck pain and headache. Medications include ibuprofen 800 mg PO TID. The injured worker was being treated for prostate cancer and is out of work for treatment of the prostate cancer. Objectively, there is tenderness to palpation over the bilateral trapezius muscles. Range of motion is normal and there is decreased sensation over the ulnar forearm. The documentation in the treatment plan indicates the injured worker is being treated with Botox for headache, Topamax dosing is increased and the treating provider ordering physical therapy to the neck. There is a neurosurgical consultation pending. There is no documentation of a functional restoration program in the treatment plan. The guidelines recommend previous methods of treating chronic pain have been unsuccessful prior to ordering a functional restoration program. The treating provider has prescribed Botox for headache, and increasing Topamax, additional physical therapy and a neurosurgical consultation is pending. As noted above, there is no contemporaneous clinical documentation with a request for a functional restoration program. There is no clinical discussion, indication or rationale for a functional restoration program. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, no contemporaneous clinical documentation on or about the

date of request for authorization and no clinical discussion, indication or clinical rationale for a functional restoration program, functional restoration program is not medically necessary.