

<b>Case Number:</b>	CM15-0036466		
<b>Date Assigned:</b>	03/05/2015	<b>Date of Injury:</b>	07/25/2001
<b>Decision Date:</b>	04/10/2015	<b>UR Denial Date:</b>	02/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/26/2015

### 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 73 year old male, who sustained an industrial injury on 07/25/2001. He has reported pain in the right and left upper extremities, left hip, left knee, and back. The diagnoses have included status post slip and fall injuring head, left side of body and right hand; left radial head fracture; right lateral and medial epicondylitis; left hip trochanteric bursitis; and obstructive sleep apnea. Treatment to date has included medications, physical therapy, surgical intervention, and gym membership. Medications have included Tramadol, Zolpidem, Lyrica, and Voltaren Gel. A progress note from the treating physician, dated 01/21/2015, documented a follow-up visit with the injured worker. The injured worker reported pain in the right elbow/hand/arm, left hip, left knee, back, bilateral shoulders, chest, head, neck, thorax, left arm/elbow/hand, and stomach; left eye decreased field of vision; and leg and feet cramping and muscle spasm. Objective findings included decreased range of motion with pain on left hip; left foot positive tenderness to palpation; right elbow decreased range of motion with tenderness to palpation; and decreased visual field in left eye. Request is being made for a prescription for Voltaren Gel; and for [REDACTED] membership with Aquatic Therapy. On 02/12/2015 Utilization Review noncertified a prescription for Voltaren Gel 1% 500; and for [REDACTED] membership with Aquatic Therapy. The CA MTUS, ACOEM and the ODG were cited. On 03/19/2015, the injured worker submitted an application for IMR for review of a prescription for Voltaren Gel 1% 500; and for [REDACTED] membership with Aquatic Therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren Gel 1% 500:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Second Edition (2004), Chapter 7, page 503 and Official Disability Guidelines (ODG), Treatment Index, 13th Edition (web), 2015, Low Back Chapter, Gym membership.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 111-113 of 127.

**Decision rationale:** Regarding the request for Voltaren gel, CA MTUS states that topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Within the documentation available for review, none of the abovementioned criteria have been documented. Given all of the above, the requested Voltaren gel is not medically necessary.

**membership with Aquatic Therapy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Second Edition (2004), Chapter 7, page 503 and Official Disability Guidelines (ODG), Treatment Index, 13th Edition (web), 2015, Low Back Chapter, Gym membership.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 46-47 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Gym Memberships.

**Decision rationale:** Regarding request for health club membership, Chronic Pain Medical Treatment Guidelines state that exercise is recommended. They go on to state that there is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. ODG states the gym memberships are not recommended as a medical prescription unless a documented home exercise program with periodic assessment and revision has not been effective and there is a need for equipment. Plus, treatment needs to be monitored and administered by medical professionals. With unsupervised programs there is no information flow back to the provider, so he or she can make changes in the prescription, and there may be a risk of further injury to the patient. Within the documentation available for review, there is no indication that the patient has failed a home exercise program with periodic assessment and revision. Additionally, there is no indication that the patient has been trained on the use of gym equipment, or that the physician is overseeing the gym exercise program. In the absence of such documentation, the currently requested health club membership is not medically necessary.

