

<b>Case Number:</b>	CM15-0081625		
<b>Date Assigned:</b>	05/04/2015	<b>Date of Injury:</b>	02/13/2014
<b>Decision Date:</b>	06/02/2015	<b>UR Denial Date:</b>	04/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/28/2015

### 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: New Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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 56 year old male who sustained an industrial injury on 02/13/2015. Diagnoses include left L5-S1 facet arthralgia, left sacroiliac arthralgia, lumbar disc injury and right chondromalacia. Treatment to date has included diagnostic studies, medications, and epidural steroid injection. A physician progress note dated 04/06/2015 documents the injured worker has complaints of pain in his low back which he rates as a 5-6 out of 10 in severity and increases up to a 9 out of 10 with activity. Medications help decrease the pain. Left L5-S1 level has flexion, rotation and side bending strain with paraspinal spasms and moderate pain. He has a positive left Gillet's sign that is questionable at left L5-S1 level. He has moderate pain upon forward flexion and extension. The right knee popliteal bursa is full with a positive Bowstring sign. There is full active range of motion. There is slight medial joint line tenderness. Treatment requested is for Aqua therapy once a week for 6 weeks, Motrin 600mg, #60, and Voltaren 1% gel #1.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Motrin 600mg, #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Nonsteroidal anti-inflammatory drug.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Naproxen Page(s): 66.

**Decision rationale:** According to MTUS guidelines, Motrin is indicated for relief of pain related to osteoarthritis and back pain for the lowest dose and shortest period of time. There is no documentation that the shortest and the lowest dose of Motrin was used. There is no clear documentation of pain and functional improvement with previous use of NSAID. Therefore, the prescription of Motrin 600mg #60 is not medically necessary.

**Voltaren 1% gel #1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, NONSELECTIVE NSAIDS Page(s): 111, 107.

**Decision rationale:** Voltaren Gel (Diclofenac) is a non-steroidal anti-inflammatory drug (NSAID). According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. There is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Diclofenac is used for osteoarthritis pain of wrist, ankle and elbow and there is no strong evidence for its use for spine pain such as cervical spine pain, shoulder and knee pain. There is no evidence of osteoarthritis. Therefore, the request for Voltaren gel 1% is not medically necessary.

**Aqua therapy once a week for 6 weeks:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22.

**Decision rationale:** According to MTUS guidelines, aquatic therapy is "recommended as an optional form of exercise therapy, where available, as an alternative to land based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. For recommendations on the number of supervised visits, see Physical medicine. Water exercise improved some components of health-related quality of life, balance, and stair climbing in females with fibromyalgia, but regular exercise and higher intensities maybe required to

preserve most of these gains. (Tomas-Carus, 2007)." There no clear evidence that the patient is obese or have difficulty performing land based physical therapy or the need for the reduction of weight bearing to improve the patient ability to perform particular exercise regimen. There is no documentation for a clear benefit expected from Aquatic therapy. Therefore the prescription of aquatic therapy once a week for 6 weeks is not medically necessary.