

<b>Case Number:</b>	CM15-0111364		
<b>Date Assigned:</b>	06/17/2015	<b>Date of Injury:</b>	06/23/2011
<b>Decision Date:</b>	07/16/2015	<b>UR Denial Date:</b>	05/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2015

### 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

### 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 45 year old male who reported an industrial injury on 6/23/2011. His diagnoses, and/or impressions, are noted to include: left foot/forefoot injury; metatarsalgia; hammer toe/claw toe; bunion/hallux valgus; rule-out scar neuroma; neuropathic pain to the left foot; and other chronic pain. No current imaging studies are noted; recent x-rays were reported taken of the left knee. His treatments have included consultations; diagnostic studies; custom foot orthotics; medication management and a return to full work duties with recommended orthotics/shoes. The progress notes of 5/5/2015 noted presentation for complaints of left foot symptoms. Objective findings were noted to include no acute distress; an antalgic gait that favored the left; scars to the lower extremity, consistent with previous surgeries; moderate 1st phalangeal tenderness; and decreased sensation to the medial aspect of the great toe/plantar, with Tinel's along the surgical scar. The physician's requests for treatments were noted to include the continuation of Voltaren Gel and the indefinite use of H-wave therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren Gel 1% quantity 5.00:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, pages 111-113.

**Decision rationale:** Voltaren Topical Gel may be recommended as an option in the treatment of osteoarthritis of the joints (elbow, ankle, knee, etc.) for the acute first few weeks; however, it not recommended for long-term use beyond the initial few weeks of treatment as in this chronic injury. Submitted reports have not demonstrated significant documented pain relief or functional improvement from treatment already rendered from this topical NSAID nor is there a contraindication to an oral NSAID use for this patient. The Voltaren Gel 1% quantity 5.00 is not medically necessary and appropriate.

**H Wave (indefinite use) quantity 1.00:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, H-Wave Stimulation, pages 115-118.

**Decision rationale:** Submitted reports have not provided any specific decreasing dose of medications or increase in ADLs as a result of the H-wave unit trial. There is no change in work status or functional improvement demonstrated to support for the purchase of this unit. The MTUS guidelines recommend a one-month HWT rental trial to be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function. The patient is without any documented consistent pain relief in terms of decreasing medication dosing and clear specific objective functional improvement in ADLs have not been demonstrated. There is also no documented failed trial of TENS unit nor any indication the patient has a home exercise program for adjunctive exercise towards a functional restoration approach per submitted report by the provider. The H Wave (indefinite use) quantity 1.00 is not medically necessary and appropriate.