

<b>Case Number:</b>	CM15-0116483		
<b>Date Assigned:</b>	06/24/2015	<b>Date of Injury:</b>	10/24/2000
<b>Decision Date:</b>	07/24/2015	<b>UR Denial Date:</b>	05/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/16/2015

### 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 58 year old male, who sustained an industrial/work injury on 10/24/00. He reported initial complaints of neck and back pain. The injured worker was diagnosed as having degenerative disc disease of lumbar spine. Treatment to date has included medication, chiropractic therapy, and physical therapy. Currently, the injured worker complains of neck and low back pain with numbness and tingling into the bilateral upper extremity. Per the physical therapy progress report (PR-2) on 10/15/14, exam noted strength of the cervical spine at 4+/5, left upper extremity grossly 5-/5, right upper extremity grossly 4+/5, range of motion: flexion at 45 degrees, extension at 20 degrees, and Spurling's test is negative. The requested treatments include Ibuprofen 800mg and Voltaren gel 1%, 15gm.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ibuprofen 800mg #60 with 1 refill:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-72.

**Decision rationale:** Regarding the request for Motrin (ibuprofen), Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, the patient does have ongoing pain with cervical and lower back osteoarthritis. As such, the currently requested Motrin is medically necessary.

**Voltaren gel 1%, 15gm with 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel Page(s): 112.

**Decision rationale:** With regard to the request for Voltaren gel, the CA MTUS recommend topical NSAIDs as an option on a short-term basis of 4 to 12 weeks. This should be applied in joints that are amenable to topical treatment, such as the knees, ankles, feet, hand and wrist. In the case of this injured worker, the patient does not have complaints relating to the knees, ankles, feet, hands and wrists. Furthermore, there is no documentation of failed oral NSAIDs. As such, this request is not medically necessary.