

<b>Case Number:</b>	CM15-0179512		
<b>Date Assigned:</b>	09/21/2015	<b>Date of Injury:</b>	03/30/2011
<b>Decision Date:</b>	10/23/2015	<b>UR Denial Date:</b>	08/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/11/2015

### 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

Certification(s)/Specialty: Preventive Medicine, Occupational 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 73 year old female, who sustained an industrial injury on March 30, 2011. The injured worker was diagnosed as having chronic low back pain, sacroiliitis, lumbosacral spondylosis, lumbar and sacral disc degeneration, right knee pain, and chronic use of opiate drugs for therapeutic purposes. Treatment and diagnostic studies to date has included a medication regimen. In a progress note dated August 19, 2015 the treating physician reports complaints of pain to the back and decreased extension and constant, dull, tingling, aching, and throbbing pain to the right sacroiliac joint that radiates to the right buttock. Examination performed on August 19, 2015 that was revealing for tenderness to the lumbar three through sacral one paravertebral muscles with spasm to the surrounding tissue; "severe", constant, aching, deep pain to the bilateral hips and the low back bilaterally with facet loading maneuvers; and tenderness and "severe", aching, and constant pain to the medial aspect of the lower extremity. On August 19, 2015 the injured worker's medication regimen included Alieve with a history of Voltaren Gel use that was noted to assist the injured worker "significantly", but did not indicate if the injured worker experienced any functional improvement with the prior use of Voltaren Gel or if the injured worker had a decrease in her pain level after use of Voltaren Gel as noted on visual analog scale. On August 19, 2015 the injured worker's pain level was rated an 8 out of 10 but the progress note did not indicate the injured worker's pain level as rated on a pain scale prior to use of her current medication regimen and after use of her current medication regimen to indicate the effects with the use of the injured worker's current medication regimen. Also, the progress note did not indicate if the injured worker experienced any functional

improvement with the use of her current medication regimen. On August 19, 2015 the treating physician requested an outpatient right sacroiliac joint injection times one, but did not indicate the specific reason for the requested procedure. On August 19, 2015 the treating physician also requested Voltaren Gel 1% 2 gm noting prior use of this medication. On August 28, 2015 the Utilization Review determined the requests for outpatient right sacroiliac joint injection times one and Voltaren Gel 1% 2 gm to be non-certified.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Outpatient right sacroiliac joint injection times 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis/Sacroiliac joint injections.

**Decision rationale:** MTUS Guidelines do not adequately address this issue. ODG Guidelines address this issue in detail and the more recent update does not support Sacroiliac (SI) joint injections unless there is a clearly demonstrated immune mediated arthropathy involving the SI joint. The injection is no longer recommended for non-specific chronic low back pain thought to be related to SI joint dysfunction. There are no unusual circumstances to justify an exception to Guidelines, the Outpatient right sacroiliac joint injection times 1 is not supported by Guidelines and is not medically necessary.

#### **Voltaren Gel 1% 2 gram: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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/Topical Analgesics.

**Decision rationale:** MTUS Guidelines do not support the use of topical NSAIDs for spinal pain and the requesting physician does not provide enough information to justify an exception to the Guidelines. Although it is documented that this individual has brought in a tube of Voltaren stating that it turns her back numb there are no other measures that supports anything other than a placebo effect. There are no measures of functional improvements secondary to its use which might justify its use on an exceptional basis. In addition, there are no prior trials of over the counter topicals which actually have more support than Voltaren for chronic spinal pain. Under these circumstances, the Voltaren Gel 1% 2 gram is not supported by Guidelines and is not medically necessary.

