

Case Number:	CM15-0068044		
Date Assigned:	04/15/2015	Date of Injury:	02/07/2013
Decision Date:	05/15/2015	UR Denial Date:	03/11/2015
Priority:	Standard	Application Received:	04/10/2015

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 66 year old male, who sustained an industrial injury on 2/07/2013. Diagnoses include asymmetric L3-4 neuro foraminal narrowing per magnetic resonance imaging (MRI) (6/14/2013), degenerative disc desiccation and early disc space narrowing with posterior disc bulging evident throughout the lumbar spine per MRI, chronic low back pain and lumbar radiculopathy. Treatment to date has included diagnostics, chiropractic, physical therapy, H wave unit and medications. Per the Primary Treating Physician's Progress Report dated 2/23/2015, the injured worker reported lumbar spine pain rated 3-4/10 on a subjective pain scale. Physical examination of the lumbar spine revealed moderate tenderness to palpation over the spinous processes of L4-5 as well as over the bilateral sacroiliac joint spaces with restricted range of motion. The plan of care included consultations, H wave therapy, chiropractic, physiotherapy and topical medication and authorization was requested for Voltaren gel 1% 100gm.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren gel 1% 100gm apply qid, 3 tubes with 1 refill: Upheld

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

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

Decision rationale: Per Guidelines, 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 for this chronic injury. Submitted reports show no significant documented pain relief or functional improvement from treatment already rendered from this topical NSAID. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. There is little evidence to utilize topical analgesic over oral NSAIDs or other pain relievers for a patient without contraindication in taking oral medications. Recent report noted chronic pain symptoms with unchanged activity level. Clinical exam is without acute changes or report of flare-up for this chronic injury. The Voltaren gel 1% 100gm apply qid, 3 tubes with 1 refill is not medically necessary and appropriate.

Physiotherapy 10 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

Decision rationale: Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physiotherapy 10 sessions is not medically necessary and appropriate.

