

<b>Case Number:</b>	CM13-0072450		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	03/30/2006
<b>Decision Date:</b>	05/30/2014	<b>UR Denial Date:</b>	12/17/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/31/2013

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 64 year old male who reported an injury on 03/03/2006. The mechanism of injury was not provided in the clinical documentation. Per the clinical note dated 11/04/2013 the injured worker received a Supartz injection to the left knee. The physical exam prior to injection revealed no inflammation to the left knee and full range of motion. Per the clinical note dated 11/11/2013 the injured worker received a second Supartz injection to the left knee. The physical exam prior to the injection revealed minimal soft tissue swelling without effusion or heat. Per the clinical note dated 06/18/2013 the injured worker has a diagnosis of mild degenerative arthritis to the left knee. The request for authorization for medical treatment was not provided in the clinical documentation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**DICLOFENAC CREAM 6.25/2.5/2%:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS, NSAIDS Page(s): 112.

**Decision rationale:** According to the MTUS Chronic Pain Medical Treatment Guidelines Voltaren® Gel 1% (diclofenac) is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The injured worker has a diagnosis of mild functional arthritis not osteoarthritis; however, there is a lack of imaging documentation to support this finding. In addition, the MTUS guidelines state that a 1% gel is indicated, there is no other strength recommended. Therefore, the request for Diclofenac 6.25/2.5/2% is not medically necessary appropriate.