

Case Number:	CM14-0062898		
Date Assigned:	07/11/2014	Date of Injury:	01/27/2013
Decision Date:	10/14/2014	UR Denial Date:	04/11/2014
Priority:	Standard	Application Received:	05/05/2014

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 California. 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 47-year-old male who reported an injury on 01/27/2013 due to an unknown mechanism. Diagnoses were industrial injury to right knee, right knee diagnostic and operative arthroscopy, Synvisc-One to the right knee. Physical examination on 03/24/2014 revealed the injured worker was status post right knee arthroscopy on 03/29/2013. He was recently authorized a course of aquatic therapy. The injured worker reported achiness, stiffness, and pain to the right knee. He was to get another Synvisc-One viscosupplementation injection. Examination revealed range of motion was 0 to 130 degrees with positive patellofemoral crepitation and positive grind test. Medications were not reported. Treatment plan was to use anti-inflammatories, use ice and elevate knee for the next few days, and continue aquatherapy. The rationale was not subsequent. The Request for Authorization was submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Gel 1%, 1 tube: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel, Page(s): 111.

Decision rationale: The decision for Voltaren Gel 1%, one tube is not medically necessary. The California Medical Treatment Utilization Schedule states Voltaren Gel 1% (diclofenac) is an FDA approved agent indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment such as the 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 gms per day (8 gms per joint per day in the upper extremity and 16 gms per joint per day in the lower extremity). The efficacy of this medication was not reported. The request does not indicate a frequency for the medication. There were no significant reports or findings to justify the use of this medication. Therefore, this request is not medically necessary.