

Case Number:	CM15-0135288		
Date Assigned:	07/27/2015	Date of Injury:	02/18/2005
Decision Date:	09/22/2015	UR Denial Date:	06/12/2015
Priority:	Standard	Application Received:	07/13/2015

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: North Carolina, Georgia
 Certification(s)/Specialty: Family Practice

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 56 year old, male who sustained a work related injury on 2/18/05. The diagnoses have included right knee pain and status post right knee surgery. Treatments have included right knee surgery, physical therapy, rest, ice therapy, anti-inflammatories and analgesics. In the Primary Treating Physician's Report dated 5/14/15 (revised 6/1/15), the injured worker complains of some mild discomfort in right knee. This is a postoperative right total knee arthroplasty visit. On physical examination, there is no effusion noted in right knee and the anterior incision has healed well. Range of motion in right knee is 5 degrees extension to 90 degrees flexion with no pain and no instability. Muscle strength in right knee is with respect to flexors and extensors. He is not working. The treatment plan includes a request for physical therapy. The requested treatment order for Voltaren gel is not noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren gel 1% Quantity: 2 DOS 05/14/2015: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section 2 Page(s): 111-113.

Decision rationale: CA MTUS recommends limited use of topical analgesics. There is limited evidence for short-term use of topical NSAID analgesics for osteoarthritis with most benefit seen in use up to 12 weeks but no demonstrated benefit beyond this time period. Voltaren gel is recommended for treatment of osteoarthritis in joints for which lend themselves to topical treatment such as ankle, knee, elbow, wrist, hand and foot. The medical record indicates that the Voltaren gel is intended for use for osteoarthritis of the knee. Voltaren gel is medically necessary.