

Case Number:	CM15-0204191		
Date Assigned:	10/21/2015	Date of Injury:	09/19/2011
Decision Date:	12/02/2015	UR Denial Date:	09/18/2015
Priority:	Standard	Application Received:	10/16/2015

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: Arizona, California
 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 68 year old female, who sustained an industrial injury on 9-19-11. Medical records indicate that the injured worker is undergoing treatment for a lateral meniscal tear of the right knee and osteoarthritis of the right knee. The injured workers current work status was not identified. On (9-11-15) the injured worker complained of occasional pain and swelling in the right knee. Examination of the right knee revealed slight patellofemoral tenderness and medial and lateral joint tenderness. No instability was noted. Range of motion revealed flexion to be 130 degrees and extension 3 degrees. Treatment and evaluation to date has included medications, x-rays of the right knee, topical analgesics and a home exercise program. An x-ray of the right knee (date unspecified) revealed mild tri-compartment osteoarthritis. A current medication list was not provided in the medical records. The current treatment request is for Voltaren Gel 1% 30 day supply # 100 with 6 refills. The Utilization Review documentation dated 9-18-15 modified the request to Voltaren Gel 1% 30 day supply # 100 with one refill (original request 6 refills).

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Gel 1%, Day Supply: 30, QTY: 100 with 6 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: According to the MTUS guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Voltaren gel is a topical analgesic. It 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. It is recommended for short-term use (4-12 weeks) for arthritis. In this case, the claimant does have arthritis. Topical NSAIDS can reach systemic levels similar to oral NSAIDS increasing the risk of GI and renal disease. There are diminishing effects after 2 weeks. The claimant was already on Voltaren prior to the request for several months. The Voltaren gel with 6 refills exceeds the time frame of benefit and length of use recommended by the guidelines and is not medically necessary.