

<b>Case Number:</b>	CM15-0205685		
<b>Date Assigned:</b>	10/22/2015	<b>Date of Injury:</b>	09/15/2001
<b>Decision Date:</b>	12/07/2015	<b>UR Denial Date:</b>	10/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2015

### 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, Oregon, Washington  
Certification(s)/Specialty: Orthopedic Surgery

### 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 60 year old female who sustained an industrial injury on 9-15-2001. A review of medical records indicates the injured worker is being treated for chronic pain syndrome, dystrophy reflex sympathy lower left knee, internal derangement knee not otherwise specified, status post lumbar fusion syndrome, and degeneration lumbar disc left. Medical records dated 9-18-2015 noted chronic low back and bilateral knee pain. Her pain was reduced from 10 out of 10 to 7 out of 10 with medication. Pain remained unchanged since the last visit. Physical examination noted normal muscle tone without atrophy in all extremities. Gait was antalgic and ambulates with a cane. Treatment has included acupuncture and Voltaren gel since at least 8-4-2015. Utilization review form dated 10-7-2015 noncertified Voltaren 1% gel.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren 1% gel, Qty 1 large tube, apply 2-4 gms 3 times daily: 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, NSAIDs (non-steroidal anti-inflammatory drugs).

**Decision rationale:** CA MTUS/Chronic Pain Medical Treatment Guidelines, page 111-112, topical analgesics NSAIDs, states that Voltaren Gel 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)." In this case there is insufficient evidence of osteoarthritis in the records from 9/18/15 to warrant Voltaren Gel. Therefore determination is not medically necessary.