

<b>Case Number:</b>	CM15-0212802		
<b>Date Assigned:</b>	11/02/2015	<b>Date of Injury:</b>	06/29/2007
<b>Decision Date:</b>	12/16/2015	<b>UR Denial Date:</b>	10/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2015

### 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: Iowa, Illinois, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

### 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 59 year old female with an industrial injury date of 06-29-2007. Medical record review indicates she is being treated for status post left total knee replacement with chronic pain and lumbar sprain and strain with degenerative disk disease and facet disease chronic. Subjective complaints (09-28-2015) included pain in the low back and knee. She continued to use medications, do a home exercise program and used ice. Objective findings (09-28-2015) included dorso-lumbar spine flexion 70 degree, extension 10 degree, right and left bending 20 degree with negative Fabere and straight leg raising. Knee exam showed healed incision from total knee replacement with no swelling. Medications included Voltaren gel (at least since 07-27-2015). Prior treatment included Flector patch, home exercise program and physical therapy. The request for Voltaren gel (1) was non-certified by utilization review on 10-14-2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren Gel Qty 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

**Decision rationale:** MTUS and ODG recommends usage of topical analgesics as an option, but also further details primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." MTUS specifically states for Voltaren Gel 1% (diclofenac) that 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." The records indicate that the treatment area would be for the knee and low back. The treating physician documents in reference to the efficacy of Voltaren Gel that "it helps", but does not quantify that statement. There has been no documentation of objective functional improvement with the use of this medication. As such, the request for Voltaren Gel Qty 1 is not medically necessary.