

<b>Case Number:</b>	CM14-0165387		
<b>Date Assigned:</b>	10/10/2014	<b>Date of Injury:</b>	04/06/2005
<b>Decision Date:</b>	11/12/2014	<b>UR Denial Date:</b>	10/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/07/2014

### 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 Illinois. 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 67-year-old male who reported an injury on 04/06/2005 due to an unknown mechanism. Diagnoses were: status post left knee total knee replacement, rule out progressive right knee degenerative joint disease, and rule out PES anserine bursitis; and leg cramps. The physical examination dated 08/20/2014 revealed complaints of bilateral knee pain with intermittent flare ups. The injured worker reported to continue to have knee cramps. The injured worker reported partial relief with current medications and the use of an H-wave unit. It was reported the injured worker was participating in a home exercise program. Examination of the left knee revealed extension was to -4 degrees. There was mild peripatellar tenderness. There was left PES anserine tenderness. There was a weak positive left patellar compression test. Left patellar apprehension test was positive. There was anterior left knee tenderness. Treatment plan was for right knee viscosupplementation, also to continue medications as directed. Medications were Cymbalta, Klonopin, and Lidoderm 5% patch. The rationale and Request for Authorization were not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren gel 1% #100gms x 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation: Pain Procedure Summary

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

**Decision rationale:** The decision for Voltaren gel 1% quantity 100 gm x2 refills 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 treatments such as the ankle, elbow, foot, hand, knee, and wrist. It has been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 gm per day (8 gm per joint per day in the upper extremity and 16 gm 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 nor does it indicate where the gel is to be used or how often. Continued use of this medication would not be supported. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, the request is not medically necessary.