

<b>Case Number:</b>	CM14-0215285		
<b>Date Assigned:</b>	01/02/2015	<b>Date of Injury:</b>	07/06/2011
<b>Decision Date:</b>	02/28/2015	<b>UR Denial Date:</b>	12/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/23/2014

### 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. 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, Hawaii  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 patient is a 52 year old female with date of injury 07/06/11. The treating physician report dated 12/14/14 (8) indicates that the patient presents with pain affecting her right knee and lower back. The physical examination findings reveal bilateral full range of motion in her knees but the right knee has tenderness to palpation. Prior treatment history includes acupuncture, lumbar brace, and icing. Current medications are Cosamin DS, Voltaren Gel (since 2011), and Etodolac. The patient has returned to regular work duty. The current diagnoses are: 1. Rotator Cuff Syndrome. 2. DDD, Lumbar. 3. Knee DJD. 4. Knee Contusion. 5. Chondromalacia of Patella. 6. Sprain of Lumbar. The utilization review report dated 12/18/14 denied the request for Voltaren Gel 1% based on usage has exceeded guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Voltaren Gel 1%:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** The patient presents with pain affecting her right knee and lower back. The current request is for Voltaren Gel 1%. The treating physician states, Continue Voltaren Gel to her right knee qid one inch each time. (9) The MTUS guidelines state, Recommended for short-term use (4-12 weeks). Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lends themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). In this case, the treating physician has documented that the patient has been using this gel since 08/17/11 (19). MTUS guidelines only recommend topical analgesics with NSAIDs for short term use. The current request is not medically necessary and the recommendation is for denial.