

<b>Case Number:</b>	CM15-0129523		
<b>Date Assigned:</b>	07/16/2015	<b>Date of Injury:</b>	03/13/1990
<b>Decision Date:</b>	08/11/2015	<b>UR Denial Date:</b>	06/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/06/2015

### 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: New Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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:

This 75 year old male sustained an industrial injury on 3/13/90. He subsequently reported widespread musculoskeletal pain. Diagnoses include bilateral knee sprain and patellofemoral arthritis. Treatments to date include MRI testing, knee surgery, injections, physical therapy and prescription pain medications. The injured worker continues to experience bilateral knee pain. Upon examination, there was tenderness to palpation over the medial and lateral joint lines. Positive grind/ patellofemoral compression testing was noted. A request for 1 Bilateral x-ray of the knee and Voltaren gel 1% 1 tube was made by the treating physician.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Bilateral x-ray of the knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Radiography (x-rays).  
<http://www.odg-twc.com/index.html>.

**Decision rationale:** According to ODG guidelines, X ray of the knee is indicated in case: Indications for imaging X-rays: Acute trauma to the knee, fall or twisting injury, with one or more of following: focal tenderness, effusion, inability to bear weight first study. Acute trauma to the knee, injury to knee  $\geq$  2 days ago, mechanism unknown. Focal patellar tenderness, effusion, able to walk. Acute trauma to the knee, significant trauma (e.g., motor vehicle accident), suspect posterior knee dislocation. Non traumatic knee pain, child or adolescent - non patellofemoral symptoms mandatory minimal initial exam anteroposterior (standing or supine) & Lateral (routine or cross-table). Non traumatic knee pain, child or adult: patellofemoral (anterior) symptoms. Mandatory minimal initial exam anteroposterior (standing or supine), Lateral (routine or cross-table), & Axial (Merchant) view. Non traumatic knee pain, adult: non trauma, non tumor, non localized pain mandatory minimal initial exam. Anteroposterior (standing or supine) & Lateral (routine or cross-table). (ACR, 2001) (Pavlov, 2000) There is no documentation that the patient is presenting red flags requiring knee X rays. There is not recent documentation of acute trauma of focal musculoskeletal signs suggestive of serious Knee pathology. Therefore, the request for 1 Bilateral x-ray of the knee is not medically necessary.

**Voltaren gel 1% 1 tube:** 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 111), Nonselective NSAIDS, page(s) 107.

**Decision rationale:** Voltaren Gel (Diclofenac) is a non-steroidal anti-inflammatory drug (NSAID). According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. There is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Diclofenac is used for osteoarthritis. There is no evidence of lower extremity osteoarthritis. Therefore request for Voltaren gel 1% 1 tube is not medically necessary.