

Case Number:	CM15-0098992		
Date Assigned:	06/01/2015	Date of Injury:	09/11/1999
Decision Date:	06/30/2015	UR Denial Date:	05/15/2015
Priority:	Standard	Application Received:	05/22/2015

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:

The injured worker is a 53 year old, female who sustained a work related injury on 9/11/99. The diagnoses have included knee pain and lumbar strain/sprain. Treatments have included left knee surgery, medications, home exercises, physical therapy, and TENS unit therapy. In the PR-2 dated 5/11/15, the injured worker complains of hip, knee and low back pain. She is having increasing pain in the right back and sciatic area. She has pain that radiates down the lateral aspect of the leg, stopping above the knee. She states the pain is intermittent aching and throbbing pain. She rates her lumbar spine pain and left knee pain a 0-3/10 with medications and a 5/10 without medications, She states the left knee pain is primary pain generator. The treatment plan for includes refills of medications and a trial of Voltaren gel.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren Gel (in tubes) QTY 3: Upheld

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

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

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 pain of wrist, ankle and elbow and there is no strong evidence for its use for spine pain such as cervical and lumbar spine. There is no evidence of right lower extremity osteoarthritis. Therefore, request for Voltaren Gel (in tubes) QTY 3 is not medically necessary.