

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/19/2013

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]

7/24/2013

7/16/2010

8/6/2013

CM13-0007896

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Voltaren gel 1%, QTY: 3** is **medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/6/2013 disputing the Utilization Review Denial dated 7/24/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/6/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Voltaren gel 1%, QTY: 3 is medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in California. 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 treatments and/or services at issue.

Expert Reviewer Case Summary:

The patient is a 41 year old female with a date of injury 7/16/10. The patient's diagnoses include: cervical pain, hand pain, lateral epicondylitis, spasm of muscle, and wrist pain. The progress report dated 7/18/13 by Dr. [REDACTED], DO noted that the patient has a history of bilateral upper extremity pain in the anterior and posterior distribution, her hands and all five digits, as well as cervical pain. It was noted that physical exam was suggestive of tenosynovitis of wrists bilateral. The patient uses Voltaren gel for topical anti-inflammatory to wrist. The patient failed Naproxen due to gastrointestinal (GI) side effects. The utilization review denial letter dated 7/24/13 noted that the patient's prior treatment included chiropractic, acupuncture, physical therapy (PT), and multiple medications including Zanaflex, amitriptyline, Flector Patch, Naproxen, Darvocet, and Voltaren gel.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- No Medical Records were submitted timely by Claim Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for Voltaren gel 1%, QTY: 3:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Topical Agents, pages 111/112, which is a part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics, pages 111-113, which is a part of MTUS.

Rationale for the Decision:

The medical records indicate that the employee has a history of bilateral upper extremity pain in the anterior and posterior distribution, and in the hands and all of the five digits, as well as cervical pain. It was noted that physical exam was suggestive of tenosynovitis of wrists bilateral. The utilization review denial letter dated 7/24/13 noted that the employee's prior treatment included chiropractic, acupuncture, physical therapy (PT), and multiple medications including Zanaflex, amitriptyline, Flector Patch, Naproxen, Darvocet, and Voltaren gel. The employee uses Voltaren gel for topical anti-inflammatory to wrist which is supported by MTUS which states "Voltaren® Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment". **The request for Voltaren gel 1%, Qty:3 is medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/hs

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.