

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



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**Independent Medical Review Final Determination Letter**

[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/23/2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/29/2013  
Date of Injury: 4/24/2003  
IMR Application Received: 8/7/2013  
MAXIMUS Case Number: CM13-0008152

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. This means we decided that all of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations, [REDACTED]

## HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & 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 physician 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.

### DOCUMENTS REVIEWED

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

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

### CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This patient is a 68-year-old man with a date of injury of 4/24/2003. Current treating diagnoses include right shoulder adhesive capsulitis, left shoulder rotator cuff tendinopathy, lumbar discogenic pain, bilateral knee patellofemoral arthrosis, and bilateral carpal tunnel syndrome. This patient was seen in a follow-up dated 7/16/2013 with complaints of midback pain as well as shoulder pain and knee pain. The patient reported that his wrists had been aching. On exam, the patient had tenderness along the medial and lateral patellar facets, and the patient had subpatellar crepitation and pain with deep knee flexion. The treating physician refilled Ultram and also prescribed Voltaren 75 mg b.i.d. as an anti-inflammatory. On the initial physician review, the reviewer reported that Voltaren is used for treatment in ankylosing spondylitis and also for osteoarthritis and that it is used for chronic therapy, which is not the case in this patient. Therefore, the request for Voltaren was noncertified.

### IMR DECISION(S) AND RATIONALE(S)

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

**1. Voltaren 75 mg QTY: 60.00 is medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Treatment Guidelines, page 71, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section on Anti-inflammatory Medication page 22, which is part of the MTUS.

The Physician Reviewer's decision rationale:

MTUS Chronic Pain Guidelines state, "Antiinflammatories are the traditional first line of treatment to reduce pain so activity and function restoration can resume."

The Guidelines give sample dosing instructions, including 75 mg b.i.d. for osteoarthritis or 25 mg 4 times per day with an extra 25-mg dose at bedtime for ankylosing spondylitis. However, these sample dosing instructions are not documented as limiting Voltaren only to those specific diagnoses. According to the medical records provided for review, this employee has been reported to have multiple inflammatory or chronic musculoskeletal diagnoses which could potentially respond to anti-inflammatory medication treatment. The request for Voltaren, including the specific dosage prescribed at 75 mg b.i.d., is consistent with MTUS Chronic Pain Guidelines. **The request for Voltaren 75mg QTY 60 is medically necessary and appropriate.**

/MCC

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.

[REDACTED]  
[REDACTED]  
[REDACTED]

CM13-0001852