

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/11/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/26/2013
Date of Injury:	4/2/2007
IMR Application Received:	8/6/2013
MAXIMUS Case Number:	CM13-0008408

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Voltaren Gel 1%, #300 is not 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 7/26/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/10/2013. 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%, #300 is not 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 43-year-old female who reported a work related injury on 04/02/2007, as a result of cumulative trauma. The clinical note dated 07/17/2013 reports the patient was seen for followup of her chronic pain complaints under the care of Dr. [REDACTED]. The provider documents the patient has undergone bilateral carpal tunnel surgeries in the distance past. The provider documents upon physical exam of the patient range of motion of the bilateral wrists were restricted. Phalen's testing was positive as well as Tinel's. The patient had positive allodynia. The provider documented the patient presented with the following diagnoses, extremity pain, reflex sympathetic dystrophy of the upper limb, and neuropathy. The provider documented the patient received the following refills, Voltaren, Lidoderm, and Flector patch.

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
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for Voltaren Gel 1%, #300:

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

The Claims Administrator did not cite a guideline in its utilization review determination letter.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Voltaren Gel 1% (diclofenac), pg. 112, which is part of the MTUS.

Rationale for the Decision:

The clinical notes evidence the employee is utilizing both oral and topical anti-inflammatories for pain complaints. A rationale to justify both oral and topical analgesics was not evidenced in the clinical notes reviewed. Furthermore, the clinical notes failed to document the employee's reports of efficacy with the current medication regimen as noted by a decrease in rate of pain on a VAS scale and increase in objective functionality. **The request for Voltaren Gel 1%, #300 is not 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: 

/ldh

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.