MEDICAL CONTESTED CASE HEARING NO. 15048

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and the Rules of the Texas Department of Insurance, Division of Workers' Compensation. For the reasons discussed herein, the Hearing Officer determines that Claimant is not entitled to Voltaren Gel 1%, dispense 3, for the compensable injury of (Date of Injury).

STATEMENT OF THE CASE

A contested case hearing was held on July 6, 2015, to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the IRO that Claimant is not entitled to Voltaren Gel 1%, dispense 3, for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by CM, ombudsman. Respondent/Carrier appeared and was represented by RJ, attorney.

EVIDENCE PRESENTED

Claimant sustained a compensable injury on (Date of Injury). Part of the compensable injury included injuries to Claimant's right elbow and right wrist. In a decision dated October 29, 2008, the Division determined that the injury also included a herniated disc at L4-5, right carpal tunnel syndrome, right lateral epicondylitis, lumbar radiculitis, and depression. Claimant's doctor, CH C, DO, prescribed Voltaren Gel, 1%, as part of the treatment regimen for radicular syndrome of the upper extremities resulting from Claimant's compensable injury. Carrier denied preauthorization for the topical medication. After a second utilization review agent upheld the initial denial of preauthorization, Claimant appealed the denial through the Independent Review Organization (IRO) process in accordance with Rule 133.308. The Department appointed Becket Systems as the IRO. On April 13, 2015, the IRO upheld Carrier's denial of preauthorization. Claimant appealed that determination to a contested case hearing.

Texas Labor Code Section 408.021 provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Health care reasonably required is further defined in Texas Labor Code Section 401.011 (22a) as health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with evidence based medicine or, if evidence based medicine is not available, then generally accepted standards of

medical practice recognized in the medical community. Health care under the Texas Workers' Compensation system must be consistent with evidence based medicine if that evidence is available. Evidence based medicine is further defined in Texas Labor Code Section 401.011 (18a) to be the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts and treatment and practice guidelines in making decisions about treatment for an individual patient. The commissioner of the Division of Workers' Compensation is required to adopt treatment guidelines that are evidence-based, scientifically valid, outcome-focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. (Texas Labor Code Section 413.011(e).) Medical services consistent with the medical policies and fee guidelines adopted by the Commissioner are presumed reasonable in accordance with Texas Labor Code Section 413.017(1).

In accordance with the above statutory guidance, the Division of Workers' Compensation has adopted treatment guidelines by Division Rule 137.100. This rule directs health care providers to provide treatment in accordance with the current edition of the Official Disability Guidelines (ODG), and such treatment is presumed to be health care reasonably required as defined in the Texas Labor Code. Thus, the focus of any health care dispute starts with the health care set out in the ODG. A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division is considered a party to an appeal. In a Contested Case Hearing (CCH), the party appealing the IRO decision has the burden of overcoming the decision issued by an IRO by a preponderance of evidence-based medical evidence. (Division Rule 133.308 (s).)

Upon appeal of the second utilization review agent's noncertification of the Voltaren Gel prescription, the IRO submitted the request to a physician reviewer that is listed as a medical doctor who is board certified in physical medicine and rehabilitation and in pain medicine. The physician reviewer upheld Carrier's denial of the prescription citing the ODG and his medical judgment, clinical experience and expertise in accordance with accepted medical standards. The physician reviewer noted that Claimant's medications included Ketoprofen 200mg daily, Ultracet 37.5/325 mg twice daily, a topical cream with no specified components, and the Voltaren Gel 1% for radicular syndrome of the upper extremities. The physician reviewer wrote that the clinical documentation submitted for review provided very limited information regarding Claimant's clinical status and that there was no indication of any ongoing osteoarthritis that would support the use of Voltaren Gel. He determined that there was no indication of significant contraindications to oral anti-inflammatory use and the use of Voltaren Gel in addition to oral anti-inflammatories would be considered duplication of therapy and not medically indicated.

With regard to the use of Voltaren Gel and other topical analgesics, the ODG has the following:

Voltaren® Gel (diclofenac)

Not recommended as a first-line treatment. See Diclofenac Sodium (Voltaren®), where Voltaren Gel is recommended for osteoarthritis after failure of an oral NSAID, or contraindications to oral NSAIDs, or for patients who cannot swallow solid oral dosage forms, and after considering the increased risk profile with diclofenac, including topical formulations. According to FDA MedWatch, postmarketing surveillance of Voltaren Gel has reported cases of severe hepatic reactions, including liver necrosis, jaundice, fulminant hepatitis with and without jaundice, and liver failure. Some of these reported cases resulted in fatalities or liver transplantation. (FDA, 2011) For more details see Topical analgesics, Non-steroidal antinflammatory agents (NSAIDs), and the diclofenac topical listing.

Diclofenac sodium (Voltaren®, Voltaren-XR®)

Not recommend diclofenac as first line due to increased risk profile. See Diclofenac listing. See also NSAIDs (non-steroidal anti-inflammatory drugs); NSAIDs, GI symptoms & cardiovascular risk; NSAIDs, hypertension and renal function; & NSAIDs, specific drug list & adverse effects for general guidelines, as well as specific Diclofenac Sodium (Voltaren®, Voltaren-XR®) listing for more information and references, where the oral form had been recommended with cautions. See also Topical analgesics, where Voltaren Gel is recommended for osteoarthritis after failure of an oral NSAID, or contraindications to oral NSAIDs, or for patients who cannot swallow solid oral dosage forms.

Diclofenac, topical (Flector®, Pennsaid®, Voltaren® Gel)

Not recommended as a first-line treatment, but recommended as an option for patients at risk of adverse effects from oral NSAIDs, after considering the increased risk profile with diclofenac. See specific topical diclofenac listings: Flector® patch (diclofenac epolamine); Pennsaid® (diclofenac sodium topical solution); & Voltaren® Gel (diclofenac). For more details, see also Topical analgesics, Non-steroidal antinflammatory agents (NSAIDs), and the diclofenac topical listing.

Topical analgesics

Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including

NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, α-adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, γ agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. Custom compounding and dispensing of combinations of medicines that have never been studied is not recommended, as there is no evidence to support their use and there is potential for harm. [Note: Topical analgesics work locally underneath the skin where they are applied. These do not include transdermal analgesics that are systemic agents entering the body through a transdermal means. For example, see Duragesic® (fentanyl transdermal system).]

Non-steroidal anti-inflammatory agents (NSAIDs): Recommended for the following indications:

Acute pain: Recommended for short-term use (one to two weeks), particularly for soft tissue injuries such as sprain/strains. According to a recent review, topical NSAIDs can provide good levels of pain relief for sprains, strains, and overuse injuries, with the advantage of limited risk of systemic adverse effects as compared to those produced by oral NSAIDs. They are considered particularly useful for individuals unable to tolerate oral administration, or for whom it is contraindicated. There appears to be little difference in analgesic efficacy between topical diclofenac, ibuprofen, ketoprofen and piroxicam, but indomethacin is less effective, and benzydamine is no better than placebo. The number needed to treat for clinical success, defined as 50% pain relief, for all topical NSAIDs combined vs. placebo was 4.5 (95% confidence interval [CI], 3.9 - 5.3) for treatment periods of 6 to 14 days. Current studies indicate 6 or 7 out of 10 patients have effective pain control with topical agents vs. 4 out of 10 with placebo. The reason for the high placebo rate is that most sprain/strain injuries improve on their own. (Massey, 2010) (Mason, 2004)

Osteoarthritis and tendinitis, in particular, that of the knee, elbow, and hand or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). (See also the Knee Chapter.) (Underwood, 2008) (Mason, 2004) (Biswal, 2006) (Green, 2002) (Niethard, 2005) (Conaghan, 2008) (Altman, 2009) (Wenham, 2010) (Zhang, 2007) (NICE, 2008) (Zhang, 2010) (Altman, 2011) The American Academy of Orthopedic Surgeons recommends topical

NSAIDs if there is increased GI risk with use of NSAIDs as one option for treatment. (Richmond, 2010) There are no studies evaluating topical ketoprofen for treatment of hand osteoarthritis. Topical ketoprofen gel has been compared to oral celecoxib, with WOMAC physical function scores significant for the later but not the topical treatment. (Rother, 2007)

Osteoarthritis of the hip and shoulder: There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the hip or shoulder.

Osteoarthritis of the low back: There is no evidence to recommend a NSAID dosage form other than an oral formulation for low back pain. (Roelofs, 2008) (Haroutiunian, 2010)

Widespread musculoskeletal pain: Not recommended.

Neuropathic pain: Not recommended as there is no evidence to support use. (Haroutiunian, 2010) (Finnerup, 2005)

General information: The theory behind using a topical NSAID is to achieve a therapeutic concentration in the tissue adjacent to the application, allowing for safe serum concentration. This would allow for less adverse GI events, eliminate first-pass metabolism and reduce risk of other GI events associated with higher systemic doses provided with oral formulations. Overall, a high concentration of drug is observed in the dermis and muscles (equivalent to that obtained orally), with less gastrointestinal effect. Plasma concentrations are 5% to 15% of those achieved systemically. (Kienzler, 2010) Topically applied NSAIDs appear to reach the synovial fluid of joints, although the mechanism for delivery remains unclear. The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. (Lin, 2004) (Bjordal, 2007) (Mason, 2004) When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. The effect appeared to diminish over time and it was stated that further research is required to determine if results were similar for all preparations. (Biswal, 2006) These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. In terms of acute pain, topical NSAIDs were found to produce a 50% reduction in pain at one week, with the most significant results obtained with use of ketoprofen, while indomethacin was barely distinguished from placebo. (Mason, 2004)

Pharmacokinetics and systemic availability: Absorption and penetration through the skin depends on the active medication, formulation (i.e. gel vs. solution), carrier-medicated transport, and penetration enhancement. Each of these differences produces differences in systemic levels attained. The carrier may also contribute to toxicity. Toxicity by dose has not been established (especially for trials that allowed for more than one joint to be treated). Excessive amounts of topical NSAID may produce higher than desired levels, hindering the advantage of a topical formulation. (Haroutiunian, 2010) (Kienzler, 2010)

Compounded formulations: There is little research available in terms of bioavailability and objective clinical endpoints for these agents. (Haroutiunian, 2010)

FDA-approved agents: At this time, the only available FDA-approved topical NSAID is diclofenac.

Voltaren® Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in a joint that lends itself to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The most common adverse reactions were dermatitis and pruritus. (Voltaren® package insert) Clinical trial data suggest that diclofenac sodium gel (the first topical NSAID approved in the US) provides clinically meaningful analgesia in OA patients with a low incidence of systemic adverse events. (Altman, 2009) The labeling for topical diclofenac has been updated to warn about drug-induced hepatotoxicity. (FDA, 2009) Voltaren Gel was effective in adults regardless of age. Treatment-related application site dermatitis was more common with Voltaren Gel, but gastrointestinal AEs were infrequent. It is recommended for osteoarthritis after failure of an oral NSAID, or contraindications to oral NSAIDs, or for patients who cannot swallow solid oral dosage forms. (Baraf, 2011) (Kienzler, 2010) See also Voltaren® Gel separate listing, where it is not recommended as a first-line treatment.

Pennsaid® (diclofenac topical solution 1.5% containing 45.5% dimithyl sulfoxide): FDA-approved for osteoarthritis of the knee. A recent study on adverse effects of this agent compared to oral diclofenac found that the latter formulation had significantly higher events. Gastrointestinal AEs orally were 39% vs. 25.4% topically ($P< 0.0001$). Cardiovascular events were 3.5% orally vs. 1.5% topically ($P=0.055$). Liver function tests were increased more commonly in those taking oral agents. The most common adverse effect was application-site reaction.

Dry skin is thought to result from the DSMO component. Long-term studies were recommended. (Roth, 2011) The dose is 40 drops to the knee four times a day. See also Pennsaid® (diclofenac sodium topical solution) separate listing, where it is not recommended as a first-line treatment.

Flector® Patch (diclofenac epolamine topical patch 1.3%): Indicated for acute strains, sprains, and contusions. Apply one patch twice daily to most painful area. See also Flector® patch (diclofenac epolamine) separate listing, where it is not recommended as a first-line treatment.

Non FDA-approved agents: Ketoprofen: This agent is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis and photosensitization reactions. (Diaz, 2006) (Noize, 2010) (Hindsen, 2006) (Devleeschouwer, 2008) (Matthieu, 2004) (Barbaud, 2009) Due to the high incidence of these reactions the French government removed this topical drug from the market in December 2009. This was subsequently overturned, with recommendations made to make the topical formulation available by prescription only, and by strengthening warnings as to adverse effects. (Lechat, 2010) Absorption of the drug depends on the base it is delivered in. (Gurol, 1996). Topical treatment can result in blood concentrations and systemic effect comparable to those from oral forms, and caution should be used for patients at risk, including those with renal failure. (Krummel 2000) Clinical trials: Numerous clinical trials are ongoing, including a phase III trial for a ketoprofen patch for treatment of soft tissue injury, acute sprain/strain, and non articular rheumatism, tendinitis and bursitis, a phase III trial for ketoprofen 10% cream for treatment of acute soft tissue injury, and a topical ketoprofen gel for muscle soreness. Clinical trials show similar results between Diclofenac gel and a ketoprofen patch formulation. (Esparza, 2007) See also Ketoprofen, topical separate listing, where it is not recommended in the U.S., as there are currently no FDA-approved versions of this product, but it is a first-line drug in Europe.

Piroxicam: There is no FDA-approved topical piroxicam agent. This drug also is known to produce drug-induced photosensitivity. (Drucker, 2011) (Barbaud, 2009) Numerous adverse effects are noted with systemic delivery of piroxicam including elevated hepatic enzymes in 1-10% in patients who receive the drug.

Adverse effects of topical NSAIDs in general: Topical NSAIDs have a high safety margin with fewer severe gastrointestinal adverse effects. Adverse drug events occur on average in about 12% of individuals, with 75% of these including rash and/or pruritus at the application site. A recent systematic review of use of topical NSAIDs in older adults found the withdrawal rates from topical agents to be

similar to that of oral NSAIDs. Gastrointestinal complaints and headaches were reported most frequently in both topical and oral NSAID groups. Anemia, liver function tests, renal abnormalities, and severe gastrointestinal events were higher in oral NSAID users. Examination of drug-related effects, including vehicles used and total dose is needed. (Makris, 2010) The use of oral NSAIDs concomitantly with topical agents is not recommended. (Peterson, 2011) See also NSAIDs, GI symptoms and cardiovascular risk; & NSAIDs, hypertension and renal function.

Cost effectiveness: Current FDA-approved topical agents are approximately six to ten times more expensive than oral over-the-counter preparations. Savings may occur due to lack of serious adverse GI effects, and the lack of necessity of taking an ulcer-protection medication.

NSAIDs, specific drug list & adverse effects

Recommended with cautions below. Disease-State Warnings for all NSAIDs: All NSAIDS have [U.S. Boxed Warning]: for associated risk of adverse cardiovascular events, including, MI, stroke, and new onset or worsening of pre-existing hypertension. NSAIDS should never be used right before or after a heart surgery (CABG - coronary artery bypass graft). NSAIDs can cause ulcers and bleeding in the stomach and intestines at any time during treatment (FDA Medication Guide). See NSAIDs, GI Symptoms and Cardiovascular Risks. Other disease-related concerns (non-boxed warnings): Hepatic: Use with caution in patients with moderate hepatic impairment and not recommended for patients with severe hepatic impairment. Borderline elevations of one or more liver enzymes may occur in up to 15% of patients taking NSAIDs. Renal: Use of NSAIDs may compromise renal function. FDA Medication Guide is provided by FDA mandate on all prescriptions dispensed for NSAIDS. Routine Suggested Monitoring: Package inserts for NSAIDs recommend periodic lab monitoring of a CBC and chemistry profile (including liver and renal function tests). There has been a recommendation to measure liver transaminases within 4 to 8 weeks after starting therapy, but the interval of repeating lab tests after this treatment duration has not been established. Routine blood pressure monitoring is recommended. Overall Dosing Recommendation: It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual patient treatment goals. Specific NSAID Classes are outlined below:

NONSELECTIVE NSAIDS: (Inhibits COX-1 and COX-2) Mechanism of action: Inhibits prostaglandin synthesis by decreasing the activity of the enzymes COX-1 and COX-2, which results in decreased formation of prostaglandins involved in the physiologic response of pain and inflammation. Side Effects: See Disease-

state warnings above. Other common side effects include the following. CNS: headache, dizziness, insomnia; Skin: rash including life-threatening skin reactions (Stevens-Johnson syndrome) **Discontinue if rash develops**; GI: abdominal cramps, nausea/vomiting, diarrhea, constipation, flatulence; Otic: Tinnitus; Hematologic: Anemia. Specific NSAIDS are listed below:

Diclofenac Sodium (Voltaren®, Voltaren-XR®) generic available: (Voltaren®, diclofenac sodium enteric-coated tablet Package Insert), (Voltaren®-XR, diclofenac sodium extended-release tablets Package Insert) See also Zorvolex (diclofenac).

Diclofenac Potassium (Cataflam®, generic available): (Cataflam®, diclofenac potassium immediate-release tablets Package Insert) Different formulations of diclofenac are not necessarily bioequivalent. Dosing: Cataflam®: Osteoarthritis: Adults: 50 mg PO 2—3 times daily. Dosages > 150 mg/day PO are not recommended. Pain: 50mg PO 3 times per day (max dose is 150mg/day). An initial dose of 100 mg PO followed by 50-mg doses may provide better relief. Voltaren®: Osteoarthritis: 50 mg PO 2—3 times daily or 75 mg PO twice daily. Dosages > 150 mg/day PO are not recommended. Ankylosing spondylitis: 25 mg PO 4 times a day with an extra 25-mg dose at bedtime if necessary. Voltaren®-XR: 100 mg PO once daily for chronic therapy. Voltaren®-XR is not indicated for the management of acute pain and should only be used as chronic maintenance therapy.

In a statement of medical necessity dated March 24, 2015, Dr. C wrote that he prescribed Voltaren Gel for radicular symptoms of the upper extremities and Claimant had been using Voltaren Gel since August of 2011 to reduce Claimant's need for oral medications and costly analgesic injections. He wrote that the Voltaren Gel targets inflammation and provides pain relief with fewer side effects than oral medications. On April 17, 2015, Dr. C wrote that the Voltaren Gel was prescribed off-label for injury exacerbation because maximum doses of oral pain medications cause undesirable, debilitating side effects. On June 9, 2015, in responding to the IRO decision upholding Carrier's denial, Dr. C wrote that the Voltaren Gel was being prescribed for radicular symptoms, but not for cervical radiculopathy. On June 19, 2015, Dr. C wrote that he believed that the Voltaren Gel was "medically reasonable and necessary for the Compensable Injury diagnoses of Lateral Epicondylitis and Carpel (sic) Tunnel Syndrome."

Dr. C's prescription for Voltaren Gel has been submitted for review to utilization review agents in the past. On March 7, 2014, a utilization review agent for Medical Review Institute of America, Inc. determined that the Voltaren Gel was medically necessary, explaining that he

recommended approval because Claimant "has been on Voltaren gel for years due to intolerance of oral NSAIDs with GI distress. The topical NSAID is supported both as an ongoing med but also as oral NSAIDs appear to be contraindicated for him." But, on December 17, 2014, another utilization review agent recommended that the prescription be denied in light of reports of cases of severe hepatic reactions, including liver necrosis, jaundice, fuminant hepatitis with and without jaundice, and liver failure, some of which resulted in fatalities. As noted previously, the IRO physician reviewer upheld Carrier's denial, finding that there was no rationale for departing from the ODG recommendations against the use of the Voltaren Gel and because the use of the Voltaren Gel duplicated Claimant's prescription for oral anti-inflammatories.

In determining the weight to be given to expert testimony, a trier of fact must first determine if the expert is qualified to offer it. The trier of fact must then determine whether the opinion is relevant to the issues at bar and whether it is based upon a solid foundation. An expert's bald assurance of validity is not enough. *See Black vs. Food Lion, Inc.*, 171 F.3rd 308 (5th Cir. 1999); *E.I. Du Pont De Nemours and Company, Inc. v. Robinson*, 923 S.W.2d 549 (Tex. 1995). Evidence is considered in terms of the general acceptance of the theory and technique by the relevant scientific community; the expert's qualifications; the existence of literature supporting or rejecting the theory; the technique's potential rate of error; the availability of other experts to test and evaluate the technique; and the experience and skill of the person who applied the technique on the occasion in question. *Kelly v. State*, 792 S.W.2d 579 (Tex.App.-Fort Worth 1990). A medical doctor is not automatically qualified as an expert on every medical question and an unsupported opinion has little, if any, weight. *Black v. Food Lion, Inc.*, 171 F.3rd 308 (5th Cir. 1999).

Claimant testified that Dr. C prescribed the Voltaren Gel on an as-needed basis for pain in his right elbow that was not controlled by his oral NSAIDs and that the use of oral NSAIDs was contraindicated because he experienced gastric distress with the use of the maximum dosages of his prescribed NSAIDs. In a response to the IRO decision, Dr. C questioned the physician reviewer's failure to mention certain documents and conclusions. The physician reviewer responded to Dr. C's comments and affirmed his opinion that the use of Voltaren Gel in combination with the oral NSAIDs was not medically reasonable or necessary. Dr. C has pointed out that he prescribed the Voltaren Gel as an off-label use and contended that there are other indications for the use of the topical NSAID other than in cases of osteoarthritis. While that is borne out by the ODG, the Hearing Officer finds that the utilization review agents' and IRO physician reviewer's opinions are consistent with the ODG recommendations against the ongoing use of a topical NSAID, including Voltaren Gel, and are more persuasive than Dr. C's recommendation for the continued use of the medication. The Hearing Officer finds that the preponderance of the evidence-based medical evidence is not contrary to the IRO's determination that Voltaren Gel 1%, prescribe 3 (three) is not reasonably necessary health care for the compensable injury of (Date of Injury).

The Hearing Officer considered all of the evidence admitted. The Findings of Fact and Conclusions of Law are based on an assessment of all of the evidence whether or not the evidence is specifically discussed in this Decision and Order.

FINDINGS OF FACT

1. The parties stipulated as follows:

   A. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

   B. On (Date of Injury), Claimant was the employee of (Employer), Employer.

   C. On (Date of Injury), Employer provided workers' compensation insurance through Liberty Mutual Insurance Company, Carrier.

   D. Claimant sustained a compensable injury on (Date of Injury).

   E. TDI appointed Becket Systems as the Independent Review Organization to review Carrier's denial of Voltaren Gel 1%, times three.

   F. The IRO upheld Carrier's denial of the request for Voltaren Gel 1%, times three.

2. Carrier delivered to Claimant a single document stating the true corporate name of Carrier, and the name and street address of Carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. The Division has determined that the compensable injury of (Date of Injury), includes injuries to the right elbow and right wrist, an L4-5 herniated disc, right carpal tunnel syndrome, right lateral epicondylitis, lumbar radiculopathy, and depression.

4. The provisions of the ODG do not support the use of Voltaren Gel 1% for the treatment of chronic conditions.

5. The preponderance of the evidence-based medical evidence is not contrary to the IRO decision that Voltaren Gel 1% is not medically necessary for the compensable injury of (Date of Injury).

6. The preponderance of the medical evidence does not support a finding that the prescription of Voltaren Gel 1% is in accordance with generally accepted standards of medical practice recognized in the medical community.

CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.

2. Venue is proper in the (City) Field Office.

3. Voltaren Gel 1%, dispense 3 is not reasonably required health care for the compensable injury of May 8, 2002.

DECISION

Claimant is not entitled to Voltaren Gel 1%, dispense 3, for the compensable injury of (Date of Injury).

ORDER

Carrier is not liable for the benefits at issue in this hearing. Claimant remains entitled to medical benefits for the compensable injury in accordance with Section 408.021.

The true corporate name of the insurance carrier is **LIBERTY MUTUAL INSURANCE COMPANY** and the name and address of its registered agent for service of process is

CORPORATION SERVICE CO.
211 EAST 7TH STREET, STE. 620
AUSTIN, TX 78701-3218

Signed this 14th day of July, 2015.

KENNETH A. HUCHTON
Hearing Officer