

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/5/2013

[REDACTED]

[REDACTED]

| | |
|---------------------------|--------------|
| Employee: | [REDACTED] |
| Claim Number: | [REDACTED] |
| Date of UR Decision: | 7/26/2013 |
| Date of Injury: | 12/31/2004 |
| IMR Application Received: | 8/5/2013 |
| MAXIMUS Case Number: | CM13-0007038 |

- 1) MAXIMUS Federal Services, Inc. has determined the request for Diclofenac cream 1% **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/5/2013 disputing the Utilization Review Denial dated 7/26/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/6/2013. 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 **Diclofenac cream 1% 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 47-year-old female who sustained an injury on 12/30/2004. The patient reports that she fell while exiting from her truck and landed on her left knee and had immediate left knee and right elbow pain. Due to ongoing complaints of left arm elbow pain despite the use of a tennis elbow brace, right thumb spica support and oral analgesics, the patient had an electromyography/nerve conduction velocity (EMG/NCV) study on 2/22/2008, which revealed mild to moderate bilateral carpal tunnel syndrome. An MRI of the left elbow on 6/10/2012 revealed mild effusion within the left elbow joint and no focal bone marrow abnormalities present and no epicondylar lesion. The patient subsequently underwent cortisone injections for lateral epicondylitis. On 3/22/2013, the patient was prescribed diclofenac cream for left knee pain. Documentation does indicate the patient has had prior left knee replacement surgery. The provider recommended ketoprofen and hydrocodone for pain.

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 Diclofenac cream 1%:

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, (2009), pages 111-112, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Topical Analgesics Section, page 112, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain guidelines state that Voltaren gel 1% (Diclofenac) is indicated for the relief of osteoarthritis pain in joints that lend themselves to topical treatment such as the ankle, elbow, foot, hand, knee, and wrist. However, Diclofenac has not been evaluated for treatment of spine, hip or shoulder pain. Overall, the guidelines support the use of diclofenac for treatment of osteoarthritis of the knee or neuropathic pain. The records provided for review indicate the employee previously underwent left knee replacement surgery and therefore no longer has osteoarthritis. Although the employee has knee pain, the records do not document of the presence of osteoarthritis or neuropathic pain to support an indication for the requested medication as recommended by the guidelines. **The request for Diclofenac cream 1% 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: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

/sab

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.