

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

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



Notice of Independent Medical Review Determination

Dated: 12/17/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/12/2013
Date of Injury:	10/19/2011
IMR Application Received:	8/5/2013
MAXIMUS Case Number:	CM13-0007270

- 1) MAXIMUS Federal Services, Inc. has determined the request for **pharmacy 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 7/12/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/4/2013. 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 **pharmacy** 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 Family Practice, 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 33-year-old female who reported an injury on 10/19/2011. The mechanism of injury involved a dog bite. Current diagnoses include lumbar radiculopathy, lumbar disc degeneration, chronic pain trauma, chronic pain other, and issues with compensable body part. Physical examination on 04/26/2013 by Dr. [REDACTED] revealed only tenderness to palpation of the lumbar spine. Previous pain medicine re-evaluation was submitted on 03/14/2013 by Dr. [REDACTED]. Objective findings included reduced range of motion of the lumbar spine with vertebral and myofascial tenderness to palpation. The current request is for diclofenac flex plus 10%/10%/5% for the right lower extremity and lower back.

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:

[REDACTED]

1) Regarding the request for pharmacy :

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 California MTUS, 2009, Chronic Pain, pgs 111-113, Topical Analgesics, which is part of the MTUS.

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

Rationale for the Decision:

California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Topical NSAIDs have been shown to be superior to placebo during the first 2 weeks of treatment for osteoarthritis. They are recommended for short term use of 4 weeks to 12 weeks. Diclofenac is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment. It has not been evaluated for treatment of the spine, hip, or shoulder. Topical lidocaine in the formulation of a dermal patch has been designated by the FDA for neuropathic pain. No other commercially approved topical formulations of lidocaine are indicated. There is no evidence for use of any muscle relaxant as a topical product. In this case, the clinical notes submitted indicate that the employee does not maintain a diagnosis of osteoarthritis that would warrant the need for treatment with a nonsteroidal anti-inflammatory medication. There is also no evidence of a failure to respond to first line treatment with oral antidepressants or anticonvulsants prior to the initiation of a topical analgesic. California MTUS Guidelines further state that any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended as a whole. **The request for pharmacy 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

/pas

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.