
Notice of Independent Medical Review Determination

Dated: 9/19/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/10/2013
Date of Injury: 11/1/2005
IMR Application Received: 7/18/2013
MAXIMUS Case Number: CM13-0001975

- 1) MAXIMUS Federal Services, Inc. has determined the retrospective request for lidocaine 5% dispensed on 6/17/13 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for ketamine 5% dispensed on 6/17/13 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request for diclofenac 1.5% dispensed on 6/17/13 **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/18/2013 disputing the Utilization Review Denial dated 7/10/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/23/2013. 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 retrospective request for lidocaine 5% dispensed on 6/17/13 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the retrospective request for ketamine 5% dispensed on 6/17/13 **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the retrospective request for diclofenac 1.5% dispensed on 6/17/13 **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 Internal Medicine 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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 10, 2013.

History of Condition:

This is a 41-year-old female with a 11/1/2005 date of injury; who sustained compensable cumulative trauma injury to her low back and right leg. 6/17/13 progress report indicates persistent lower back pain radiating to the lower extremities. There is also right-sided thoracic pain with intermittent radiation into the right side of the neck. Physical exam demonstrates lumbar tenderness. Treatment to date has included physical therapy, chiropractic care, acupuncture, CBT, and recent 24 acupuncture visits.

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 for Independent Medical Review
- Utilization Review from Claims Administrator
- Medical records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the retrospective request for lidocaine 5% dispensed on 6/17/13:

Medical Treatment Guideline(s) 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 111-113, which are part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured on 11/1/2005 and presents with low back and right leg pain. The employee has been treated with physical therapy, chiropractic care, cognitive behavioral therapy, and approximately 24 sessions of acupuncture treatment. The employee's most recent examination in the records submitted and reviewed document decreased flexion and localized pain in the lumbar spinal area. In July 2013, the employee indicated that pain is controlled with Tramadol and some relief with lidoderm ointment. A request was submitted for lidocaine 5%.

The MTUS Chronic Pain Guidelines indicate that use of topical lidocaine may be appropriate for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). The MTUS Chronic Pain Guidelines also indicate that further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. In addition, there is little evidence to utilize topical non-steroidal anti-inflammatory drugs (NSAIDs) for treatment of osteoarthritis of the spine, hip or shoulder. The retrospective request for lidocaine 5% dispensed on 6/17/13 is not medically necessary and appropriate.

2) Regarding the retrospective request for ketamine 5% dispensed on 6/17/13:

Medical Treatment Guideline(s) 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 111-113, which are part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured on 11/1/2005 and presents with low back and right leg pain. The employee has been treated with physical therapy, chiropractic care, cognitive behavioral therapy, and approximately 24 sessions of acupuncture treatment. The employee's most recent examination in the records submitted and reviewed document decreased flexion and localized pain in the lumbar spinal area. In July 2013, the employee indicated that pain is controlled with Tramadol

and some relief with lidoderm ointment. A request was submitted for ketamine 5%.

The MTUS Chronic Pain Guidelines indicate ketamine is currently only recommended for treatment of neuropathic pain in refractory cases in which all primary and secondary treatment has been exhausted. Topical ketamine has only been studied for use in non-controlled studies for CRPS and post-herpetic neuralgia. Topical ketamine is not recommended for treatment of back or leg pain. The retrospective request for ketamine 5% dispensed on 6/17/13 is not medically necessary and appropriate.

3) Regarding the retrospective request for diclofenac 1.5% dispensed on 6/17/13:

Medical Treatment Guideline(s) 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 111-113, which are part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee was injured on 11/1/2005 and presents with low back and right leg pain. The employee has been treated with physical therapy, chiropractic care, cognitive behavioral therapy, and approximately 24 sessions of acupuncture treatment. The employee's most recent examination in the records submitted and reviewed document decreased flexion and localized pain in the lumbar spinal area. In July 2013, the employee indicated that pain is controlled with Tramadol and some relief with lidoderm ointment. A request has been submitted for diclofenac 1.5%.

The MTUS Chronic Pain Guidelines indicate that topical agents recommended for relief of osteoarthritic joint pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) include topical Voltaren (diclofenac) gel 1%. However, its use has not been evaluated for treatment of the spine, hip or shoulder. The request for diclofenac 1.5% 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;

Richard C. Weiss, MD, MPH, MMM, PMP
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.