
Notice of Independent Medical Review Determination

Dated: 10/14/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/11/2013
Date of Injury:	6/27/1998
IMR Application Received:	7/24/2013
MAXIMUS Case Number:	CM13-0003150

- 1) MAXIMUS Federal Services, Inc. has determined the request for Voltaren Gel #3 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Lidoderm patch #90 **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/24/2013 disputing the Utilization Review Denial dated 7/11/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/29/2013. 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 #3 **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Lidoderm patch #90 **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 & 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.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated July 12, 2013:

“According to the records made available for review, this is a 50-year-old female patient, s/p injury 6/27/98. The patient most recently (6/12/13) presented with low back pain. Physical examination revealed decreased and painful L/S ROM. Current diagnoses include post laminectomy syndrome and chronic pain syndrome. Treatment to date includes medications. Treatment requested is Voltaren Gel #3 and Lidoderm patch #90 3 patches per day, 12 hr. on, 12 hr. off.”

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 (dated 7/24/13)
- Utilization Review Determination from [REDACTED] (dated 7/11/13)
- Employee medical records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for Voltaren Gel #3:

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) which is a part of Medical Treatment Utilization Schedule (MTUS), and Official Disability Guidelines (ODG), Pain Chapter which is not a part of 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, and specifically cites MTUS Chronic Pain Medical Treatment Guidelines (2009) pg. 112.

Rationale for the Decision:

The employee sustained a work-related injury on June 27, 1998 to the lower back. Medical records provided for review indicate treatments have included physical therapy and medication management. The request is for Voltaren gel #3.

The MTUS Chronic Pain Treatment guidelines indicate Voltaren gel for relief of osteoarthritis pain in joints that lends themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. The medical records provided for review indicates that the employee has decreased and painful range of motion of the lumbar spine which is not recommended by the guidelines. Therefore, the request for Voltaren gel #3 is not medically necessary and appropriate.

2) Regarding the request for Lidoderm patch #90:

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) which is a part of Medical Treatment Utilization Schedule (MTUS), and Official Disability Guidelines (ODG), Pain Chapter which is not a part of 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 sustained a work-related injury on June 27, 1998 to the lower back. Medical records provided for review indicate treatments have included physical therapy and medication management. The request is for Lidoderm patch #90.

The Chronic Pain guidelines state Lidocaine is indicated for neuropathic pain after there has been evidence of a trial of first-line therapy such as tricyclic or SNRI antidepressants or an EAD such as gabapentin or Lyrica. The documentation submitted for review details only that the employee has decreased painful range of motion of the lumbar spine. There were no imaging

studies, electrodiagnostic testing, or comprehensive evaluation of the employee submitted for review to detail a neuropathic component of pain. Furthermore, the employee is currently prescribed Neurontin 800 mg; however, there is no clear indication that the patient is recalcitrant to Neurontin. Therefore, the request for Lidoderm patch #90 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
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/hs

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.