

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

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

MAXIMUS
Federal Services



Notice of Independent Medical Review Determination

Dated: 11/22/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/6/2013
Date of Injury:	10/1/2005
IMR Application Received:	8/15/2013
MAXIMUS Case Number:	CM13-0012061

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

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/15/2013 disputing the Utilization Review Denial dated 8/6/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/30/2013. 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 Duragesic patch **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.

Expert Reviewer Case Summary:

This case is in regards to a patient who sustained an injury on 10/1/2005 causing neck, lower back, and hip and shoulder pain. Patient's diagnosis relevant to the case include: Chronic Pain Syndrome, Sacroilitis, Impingement syndrome of the right shoulder, chronic low back pain, multi-level cervical spine disc disease, enthesopathy of the right hip, muscle spasms, and carpal tunnel syndrome. The clinical issue being addressed in this case is whether the Duragesic patch was medically necessary for this patient.

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 Duragesic patch:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the MTUS Duragesic (fentanyl transdermal system), which is a part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines Part 2: Duragesic® (Fentanyl transdermal system) and page 44 which is a part of the MTUS.

Rationale for the Decision:

The rationale for the above decision on the Duragesic patch not medically appropriate in this specific case is due to the following guidelines of the MTUS: “Not recommended as a first-line therapy. Duragesic is the trade name of a Fentanyl transdermal therapeutic system, which releases Fentanyl, a potent opioid, slowly through the skin. The FDA-approved product labeling states that Duragesic is indicated in the management of chronic pain in employees who require continuous opioid analgesia for pain that cannot be managed by other means.”

A review of the medical records and documentation indicates there is no documentation by any of the treating physicians that the employee’s pain is severe enough which it cannot be managed by other means or medications besides continuous opioid analgesia. Therefore on the above basis the request for the Duragesic patch is not medically necessary. **The request for Duragesic patch 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

/cmol

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.