

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/18/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/31/2013
Date of Injury: 12/2/2010
IMR Application Received: 8/13/2013
MAXIMUS Case Number: CM13-0013004

DEAR [REDACTED],

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology, and Pain Medicine, and is licensed to practice in Florida. 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 physician 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 disputed items/services.

DOCUMENTS REVIEWED

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)

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 57-year-old male who reported an injury on 12/10/2010. The patient is currently diagnosed with new onset of acute left L5 pain and left lower extremity weakness, left lumbar facet joint pain, left lumbar facet arthropathy, central disc protrusion with neural foraminal stenosis, lumbar degenerative disc disease, and lumbar sprain and strain. The patient was most recently evaluated by Dr. [REDACTED] on 09/25/2013. Current medications include oxycodone 20 mg, promethazine 25 mg, and OxyContin 40 mg. Physical examination revealed tenderness to palpation, restricted lumbar range of motion, positive Gaenslen's and Patrick's maneuver on the left, 5/5 muscle strength in all limbs, and decreased sensation to touch in the left L5 dermatome. Recommendations included a transforaminal epidural steroid injection and continuation of current medications.

IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

1. Oxycontin 20mg is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which are part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Page 74-82, which are part of the MTUS.

The Physician Reviewer's decision rationale:

California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. Opioids should be discontinued if there is no

overall improvement in function, unless there are extenuating circumstances. As per the clinical notes submitted, the employee continues to present with complaints of lower back pain with radiation to the left lower extremity. There is no documentation of objective functional improvement or a decrease in medication consumption despite the ongoing use of this medication. Satisfactory response to treatment has not been indicated by a decrease in pain, increase in level of function, or improved quality of life. Therefore, continuation cannot be determined as medically appropriate. It is noted, previous utilization review reports were submitted on 07/31/2013 and 08/02/2013, where a non-certification was issued for the requested medication and tapering or weaning should have occurred. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified. **The request for Oxycontin 20mg is not medically necessary and appropriate.**

2. Oxycodone 30mg is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which are part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Page 74-82, which are part of the MTUS.

The Physician Reviewer's decision rationale:

California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. Opioids should be discontinued if there is no overall improvement in function, unless there are extenuating circumstances. As per the clinical notes submitted, the employee continues to present with complaints of lower back pain with radiation to the left lower extremity. There is no documentation of objective functional improvement or a decrease in medication consumption despite the ongoing use of this medication. Satisfactory response to treatment has not been indicated by a decrease in pain, increase in level of function, or overall improved quality of life. Therefore, continuation cannot be determined as medically appropriate. It is noted, previous utilization review reports were submitted on 07/31/2013 and 08/02/2013, where a non-certification was issued for the requested medication and tapering or weaning should have occurred. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified. **The request for Oxycodone 30mg is not medically necessary and appropriate.**

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.

[REDACTED]

CM13-0013004