

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

December, 20, 2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 8/8/2013
Date of Injury: 5/22/2007
IMR Application Received: 8/20/2013
MAXIMUS Case Number: CM13-0013637

Dear Mr./Ms. [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: OVERTURN. This means we decided that all 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, has a subspecialty in 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:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

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 claimant is a 65-year-old female with date of injury of 05/22/2007. The current clinical records for review include a 09/09/2013 office assessment by [REDACTED], MD, indicating current complaints of low back pain with bilateral radiating leg pain. He gives a VAS score of 5/10 to the low back and 0/10 to the bilateral legs. He indicates the claimant is status post implementation of a spinal cord stimulator 08/18/2013 that has resulted in complete relief of the leg pain and 50% reduction in bilateral sacroiliac joint pain since placement of the device. A second procedure on 08/15/2013 took place for implementation of a rechargeable sensor pulse generator. At present, it states the claimant's use of medications has included Savella, a selective serotonin reuptake inhibitor, Gabapentin, and Topamax, as well as oxycodone, which has "provided adequate control of incidental low back and left leg radicular pain associated with activities of daily living." Side effects are not noted with the medications. Physical examination continued to show motor strength at 3+/5, weakness to the bilateral hip flexors, and 4-/5 to left hip abduction and extension. The claimant's diagnosis was that of failed low back syndrome status post implanted thoracic and sacroiliac peripheral neural electrodes with pulse generator. She was to continue at that time with medications in the form of Gabapentin, topiramate, Savella, zolpidem, and hydromorphone/APAP 10/325 mg.

IMR DECISION(S) AND RATIONALE(S)

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

1. Hydromorphone/APAP 10/325 #60 is medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Criteria for use of Opioids, pages 76-80, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opioids, which is part of the MTUS.

The Physician Reviewer's decision rationale:

Based on California MTUS Chronic Pain Medical Treatment Guidelines, continued role of this opioid analgesic would appear warranted. The employee is being treated for failed lumbar spine syndrome with implantable stimulator and continued use of narcotic analgesics. The records for review indicate significant benefit from the recent stimulator placement with the employee's pain complaints appropriately managed with the dose of medicine being provided. The employee has been on a stable dose of this medication without documentation of misuse for some time. The continued role of this agent would appear to be medically warranted. **The request for hydromorphone/APAP 10/325 #60 is 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]
[REDACTED]
[REDACTED]
[REDACTED]

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