

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 10/30/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/5/2013
Date of Injury:	5/8/1976
IMR Application Received:	7/19/2013
MAXIMUS Case Number:	CM13-0002128

- 1) MAXIMUS Federal Services, Inc. has determined the request for OxyContin 40MG #90 **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for Oxycodone 15MG #180 **is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/19/2013 disputing the Utilization Review Denial dated 7/5/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/24/2013. 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 OxyContin 40MG #90 **is medically necessary and appropriate.**

- 2) MAXIMUS Federal Services, Inc. has determined the request for Oxycodone 15MG #180 **is medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent expert reviewer 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 and 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 5, 2013:

“This is a patient with a history of chronic pain, treated by Dr. [REDACTED] with chronic Opioid pain medications. The patient is 79 years old, and has lumbar DDD / radiculopathy, failed back surgery syndrome, cervical DDD/radiculopathy and cervical disc herniation. The most recent report notes that the patient states that pain is constant and severe, rated at 10/10 on VAS. Pain medications are not working due to increased tolerance. He is noted only to be on OxyContin 40 mg TID and Oxycodone 15 mg Q4. No pain contract is discussed. There is no documentation of UDS monitoring.”

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 (received 07/19/2013)
- Utilization Review Determination from [REDACTED] dated (07/05/2013)
- Employee medical records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for OxyContin 40MG #90:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), the Chronic Pain Medical Treatment Guidelines (2009), which is part of the Medical Treatment Utilization Schedule (MTUS), and the Official Disability Guidelines (ODG) (Current Version), which is not a part of the Medical Treatment Utilization Schedule (MTUS). The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines Long-term Opioid use, page 88-89, which is part of MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 5/8/1976, resulting in lower back injury. The request is for **OxyContin 40MG #90**.

MTUS/Chronic Pain Medical Treatment Guidelines note that a satisfactory response to treatment may be indicated by the individual's decreased pain, increased level of function, or improved quality of life. The medical records provided for review contain documentation that the employee suffers from chronic pain. The medical report of 06/17/2013 states the employee's pain was rated at 10/10. The medical records show the employee's improvement of pain with medication is from 9-10/10 to 6/10 and does not notice the improvement as much during a flare. **The request for OxyContin 40MG #90 is medically necessary and appropriate.**

2) Regarding the request for Oxycodone 15MG #180:

Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chronic Pain Medical Treatment Guidelines (2009), which is part of the Medical Treatment Utilization Schedule (MTUS), and the Official Disability Guidelines (ODG) (Current Version), which is not a part of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009) Long-term Opioid use, page 88-89, which is part of MTUS.

Rationale for the Decision:

The employee sustained a work-related injury on 5/8/1976, resulting in lower back injury. The request is for **Oxycodone 15MG #180**.

MTUS/Chronic Pain Medical Treatment Guidelines for chronic pain note that a satisfactory response to treatment may be indicated by the individual's decreased pain, increased level of function, or improved quality of life. The medical records provided for review contain documentation that the employee suffers from chronic pain. The medical report of 06/17/2013 states the employee's pain was

rated at 10/10. The medical records show the employee's improvement of pain with medication is from 9-10/10 to 6/10 and does not notice the improvement as much during a flare. **The request for Oxycodone 15MG #180 is 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

/mbg

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.