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**Notice of Independent Medical Review Determination**

Dated: 11/23/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/2/2013  
Date of Injury: 12/8/2010  
IMR Application Received: 7/22/2013  
MAXIMUS Case Number: CM13-0002622

- 1) MAXIMUS Federal Services, Inc. has determined the request for **one (1) prescription of Duragesic 100mcg/hr patch #30 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **one (1) prescription of Norco 10/325mg #120 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **one (1) prescription of Tegaderm 4"x4" dressing/Tegaderm 4 #30 with three (3) refills is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/22/2013 disputing the Utilization Review Denial dated 7/3/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/25/2013. 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 **one (1) prescription of Duragesic 100mcg/hr patch #30 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **one (1) prescription of Norco 10/325mg #120 is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **one (1) prescription of Tegaderm 4"x4" dressing/Tegaderm 4 #30 with three (3) refills 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 and Rehabilitation and is licensed to practice in Illinois. 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 claimant is a 47-year-old female who has complaints of back pain. On 04/29/2013, she was taken to surgery by [REDACTED], MD for preoperative diagnoses of L4-5 and L5-S1 spondylosis and spinal stenosis. Procedure performed at that time was an L4-5 and L5-S1 anterior discectomy with decompression, anterior spinal fusion, and use of infused bone morphogenetic protein and bone substitute putty. On 04/30/2013 and 05/01/2013, she was seen for PT and OT. On 05/05/2013, she was discharged from the hospital. She returned to clinic on 05/29/2013 with evaluation by [REDACTED], MD. At that time, medications included Flexeril 10 mg, Duragesic 100 mcg/hr patch 1 patch every 2 days, gabapentin 300 mg, Lidoderm 5% patch, Norco 10/325 mg tablet, and Tegaderm dressing to be applied for surgical wound. It was noted then pain was rated at 4/10 and activity level had increased and she was taking medications as prescribed and were working well. She returned to clinic on 07/11/2013 with further evaluation by [REDACTED], MD. At that time, she was still on Norco, Duragesic, docusate sodium, Senokot, gabapentin, Lidoderm, Tegaderm, and Flexeril. The medications were refilled at that time but it was not indicated what her pain scale was.

### **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 7/22/13)
- Utilization Review Determination from [REDACTED] (dated 7/2/13)
- Employee medical records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

#### **1) Regarding the request for one (1) prescription of Duragesic 100mcg/hr patch #30:**

##### 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), Fentanyl, Opioid dosing calculator, when to discontinue opioids, and Weaning of Medications, which is a part of MTUS.

The Expert Reviewer based his/her decision on Chronic Pain Medical Treatment Guidelines (2009), Duragesic, pg. 44, Fentanyl, pg. 47 and Opioids, On-going Management, pg. 78, which is a part of MTUS.

##### Rationale for the Decision:

The medical records reviewed indicate that this employee had been taken to surgery on 04/29/2013 and underwent decompression and fusion 2 levels in the lumbar spine and was discharged from 05/05/2013. On a returned visit to the clinic on 05/29/2013, it was noted that the pain scale was rated at 4/10 with current medication. On 07/11/2013, the pain scale was not noted. The records do not objectively identify the employee's pain. The MTUS Chronic Pain Guidelines indicate that this medication is "not recommended as a first line therapy". Furthermore, guidelines indicate for ongoing management of medication such as this, there should be documentation of the "4 A's", analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. The medical records provided for review do not indicate that the employee has significant pain as her pain scale is not identified objectively. It was not noted whether activities were increasing or decreasing at that time. A drug screen was not provided to objectively document that the employee is not aberrant. Therefore, at least of the 3 of the "4 A's" were not specifically addressed on last clinical note. The efficacy of this medication has not been demonstrated on a most recent clinical exam. **The request for one (1) prescription of Duragesic 100mcg/hr patch #30 is not medically necessary and appropriate.**

#### **2) Regarding the request for one (1) prescription of Norco 10/325mg #120:**

##### 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), Hydrocodone-acetaminophen, which is a part of MTUS.

The Expert Reviewer based his/her decision on Chronic Pain Medical Treatment Guidelines (2009), Opioids, On-going Management, pg. 78, which is a part of MTUS.

Rationale for the Decision:

The medical records reviewed indicate that this employee had been taken to surgery on 04/29/2013 and underwent decompression and fusion 2 levels in the lumbar spine and was discharged from 05/05/2013. On a returned visit to the clinic on 05/29/2013, it was noted that the pain scale was rated at 4/10 with current medication. On 07/11/2013, the pain scale was not noted. The records do not objectively identify the employee's pain. The MTUS Chronic Pain Guidelines indicate that this medication is "not recommended as a first line therapy". Furthermore, guidelines indicate for ongoing management of medication such as this, there should be documentation of the "4 A's", analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. The medical records provided for review do not indicate that the employee has significant pain as her pain scale is not identified objectively. It was not noted whether activities were increasing or decreasing at that time. A drug screen was not provided to objectively document that the employee is not aberrant. Therefore, at least of the 3 of the "4 A's" were not specifically addressed on last clinical note. The efficacy of this medication has not been demonstrated on a most recent clinical exam.

**The request for one (1) prescription of Norco 10/325mg #120 is not medically necessary and appropriate.**

**3) Regarding the request for one (1) prescription of Tegaderm 4"x4" dressing/Tegaderm 4 #30 with three (3) refills:**

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

The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines, Low Back Chapter, Wound dressings, which is not a part of MTUS.

Rationale for the Decision:

The records reviewed indicate the tegaderm dressing is to be applied to the surgical wound. The most recent clinical note is 07/15/2013 fails to reveal any significant problems with the wound. The most recent clinical note from Dr. [REDACTED] on 07/11/2013 also failed to indicate any significant wound issues. The surgery was performed on 04/29/2013 and as such, the surgical wound should have been healed without further complications and/or need for this device. The Official Disability Guidelines indicate that wound dressings are recommended for chronic wounds. The medical records provided for review indicate that does not appear to be a chronic wound; therefore, rationale for prescribing Tegaderm dressing at this time with 3 refills has not been demonstrated. There is lack of documentation to indicate the employee was having trouble with the duragesic patch falling off. **The request for one (1) prescription of Tegaderm 4"x4" dressing/Tegaderm 4 #30 with three (3) refills 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, 18<sup>th</sup> Floor  
Oakland, CA 94612

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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.