MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
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MAXIMUS Federal Services

Notice of Independent Medical Review Determination

Dated: 11/7/2013

Employee:	
Claim Number:	
Date of UR Decision:	7/19/2013
Date of Injury:	8/17/2009
IMR Application Received:	7/31/2013
MAXIMUS Case Number:	CM13-0004996

1) MAXIMUS Federal Services, Inc. has determined the request for Hydrocodone/APAP 10/325mg, #60 **is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for Cefadroxil 500mg, #20 **is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for Ondansetron ODT 8mg, #30 **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/31/2013 disputing the Utilization Review Denial dated 7/19/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/13/2013. 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 Hydrocodone/APAP 10/325mg, #60 **is not medically necessary and appropriate.**

2) MAXIMUS Federal Services, Inc. has determined the request for Cefadroxil 500mg, #20 **is not medically necessary and appropriate.**

3) MAXIMUS Federal Services, Inc. has determined the request for Ondansetron ODT 8mg, #30 **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 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:
The patient is a 57-year-old male who reported an injury on 08/17/2009. The operative report dated 10/29/2009 reported the patient underwent a left knee partial medial and lateral meniscectomy as well as chondroplasty. The clinical note dated 09/05/2012 reported the patient had complaints of 10/10 left knee pain. The patient was recommended for physical therapy and injections. A note and urine drug screen report dated 09/11/2012 reported the patient's sample collected on 09/05/2012 was only positive for Tramadol. The patient was noted to have consistent results with prescribed medications. Initial pain management evaluation completed on 09/28/2012 reported the patient had complaints of left knee numbness and tingling. The patient was recommended for Ultram and Norco at that time. The operative report dated 01/23/2013 reported the patient underwent a left total knee arthroplasty. Followup on 02/08/2013 reported the patient complained of 8/10 left knee pain. The patient reported that 25% to 50% of symptoms were improved due to medications. The clinical note on 03/11/2013 reported the patient complained of 6/10 pain. The patient reported 25% to 50% improvement with medication and physical therapy. The patient was recommended for continued therapy. Medications were not refilled as they were not due at that time. A urine drug screen report dated 03/22/2013 reported the sample collected on 03/11/2013 was positive for Tramadol and hydrocodone. A followup visit on 04/15/2013 reported the patient complained of 5/10 pain. The patient continued to report 25% to 50% improvement with medications and physical therapy. An appeal letter dated 05/22/2013 reported that request for hydrocodone, Cefadroxil, and Ondansetron were denied. The letter asked for reconsideration given the need for pain relief, antibiotic therapy, and

reduction of potential nausea. Utilization review letter dated 07/19/2013 reported that medications were again denied due to lack of additional information.

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** Hydrocodone/APAP 10/325mg, #60**:**

   Section of the Medical Treatment Utilization Schedule 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 based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opioids, criteria for use, page 76-78 and Hydrocodone, page 91, which is part of the MTUS.

   Rationale for the Decision:
   The Chronic Pain guidelines recommend ongoing use of opioids to include Hydrocodone when there is documentation of the 4 A's. The 4 A's consist of analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors. California MTUS Guidelines also state that "Hydrocodone is used for patients with moderate to moderately severe pain." A review of the submitted medical records indicates that the employee is status post left total knee replacement in 01/2013. Clinical notes report that the employee has undergone consistent urine drug screens for the use of Hydrocodone. The employee is also noted to have moderate to moderately severe pain with 25% to 50% reduction with the current medication regiment. **The request for Hydrocodone/APAP 10/325mg #60 is medically necessary and appropriate.**

2) **Regarding the request for** Cefadroxil 500mg, #20**:**

   Section of the Medical Treatment Utilization Schedule 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 (ODG), Infectious Disease Chapter, Cefadroxil (Duricef).

Rationale for the Decision:
The Official Disability Guidelines (ODG) state that "Cefadroxil is recommended as first line treatment for infections." A review of the submitted medical records indicates that the employee is now approximately 9 months status post left total knee replacement. The documentation submitted for review does not support that ongoing need for prophylactic antibiotic therapy. There is a lack of diagnostic findings to suggest the employee has an ongoing active infection. **The request for Cefadroxil 500mg, #20 is not medically necessary and appropriate.**

3) **Regarding the request for** Ondansetron ODT 8mg, #30**:**

Section of the Medical Treatment Utilization Schedule 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 (ODG) Pain Chapter, Ondansetron (Zofran).

Rationale for the Decision:
The Official Disability Guidelines (ODG) state that "Ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use." The documentation submitted for review fails to demonstrate that the employee has current subjective complaints of nausea or vomiting. The employee is 9 months status post surgical intervention and would not need use of this medication for prophylactic treatment in the perioperative phase. **The request for Ondansetron ODT 8mg, #30 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,

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

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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.