

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

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Dated: 11/12/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/19/2013  
Date of Injury: 11/3/1973  
IMR Application Received: 8/2/2013  
MAXIMUS Case Number: CM13-0006448

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Duragesic 100mcg #15 is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Percocet 10/325mg #84 is medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/2/2013 disputing the Utilization Review Denial dated 7/19/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/27/2013. 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 **Duragesic 100mcg #15 is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Percocet 10/325mg #84 is 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 85 Y, M with a date of injury 11/3/73, his diagnoses include failed back syndrome, lumbar radiculopathy, thoracic spondylosis, Alzheimer's disease with cognitive and memory deficits, bilateral shoulder pain, obstructive sleep apnea, status post lumbar fusion with multiple spine surgeries, permanent spinal cord stimulator, 05/11/09, right knee replacement, 2006. The progress report dated 8/30/13 by [REDACTED], M.D. noted that the patient reported pain rated at 5/10. His pain is worse if medication is not taken on time and not using stimulator. The patient has relief with PT and he reports approximately 50 percent of his pain is eliminated by the pain medication. The patient's current medications included Voltaren Gel daily to arms and legs qid prn, Fentanyl patch 100 mcg every 48 hours (wife applies), Percocet 10/325 mg every 4 hours prn, Celebrex 200 mg daily, Cymbalta 60 mg daily at night, Ambien 5-10 mg qhs, Lidoderm patches prn, 3 L O2 at night, Tylenol extra strength prn when out of Percocet, Vitamin D, Dulcolax 2 tabs daily for constipation. It was noted that the treater discussed the need for his wife to monitor his meds as the pill count was not appropriate. His wife had previously been managing the medication, but when she was hospitalized, the patient was left to do it himself.

### **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 Duragesic 100mcg #15:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

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

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pgs 44, 47, 75, & 93, which is part of the MTUS.

Rationale for the Decision:

The Duragesic patches are used as a long acting opioid to provide around the clock analgesia, which is supported by the MTUS Chronic Pain Guidelines. The submitted records for review indicate that the employee suffers from many years of chronic pain and has multiple failed spine surgeries. The records indicate that the employee's pain is reduced 50% with the pain medications and authorization is recommended. **The request for Duragesic 100mcg #15 is medically necessary and appropriate.**

**2) Regarding the request for Percocet 10/325mg #84:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

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

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Short-acting/Long-acting opioids, pg. 75, which is part of the MTUS, and the Chronic Pain Medical Treatment Guidelines, Long-term Opioids use, page 88-89, which is part of the MTUS.

Rationale for the Decision:

The employee uses the Duragesic patches as a long acting opioid to provide around the clock analgesia and Percocet as a short acting opioid for breakthrough pain, which is supported by the MTUS Chronic Pain Guidelines. The submitted records for review indicate that the employee suffers from many years of chronic pain and has had multiple failed spine surgeries. The medical records indicate that the employee's pain is reduced 50% with the pain medications and authorization is recommended. **The request for Percocet 10/325mg #84 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,

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.