

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: **11/25/2013**

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/22/2013
Date of Injury:	4/6/2011
IMR Application Received:	8/15/2013
MAXIMUS Case Number:	CM13-0011844

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Hydrocodone/acetaminophen 10/325mg #135** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Ketoprofen 75mg #90** is **medically necessary and appropriate**.

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/15/2013 disputing the Utilization Review Denial dated 7/22/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/24/2013. 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 **Hydrocodone/acetaminophen 10/325mg #135** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Ketoprofen 75mg #90** 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 Internal Medicine, 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 54 yo male who sustained an injury on 04/06/2001. He is being treated for neck, back, and wrist pain. On recent examination he has decreased cervical and lumbar range of motion with sensory changes in the upper extremities and positive carpal tunnel tests. A lumbar spine MRI on 4/13 revealed degeneration with diffuse canal narrowing and severe neural foraminal narrowing at L5-S1 bilaterally. A cervical MRI obtained at the same time showed diffuse disc bulging with multiple levels of foraminal narrowing. He has been treated with medical therapy with Hydrocodone/acetaminophen, Ketoprofen, chiropractic, and physical therapy.

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/acetaminophen 10/325mg #135:

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, Opioids, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pgs. 80, 81, 92, which are part of the MTUS.

Rationale for the Decision:

There is no documentation provided necessitating the ongoing use of Hydrocodone/APAP 10/325 for the employee's chronic pain condition. The literature indicates that in chronic pain analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs. Opioid therapy for pain control should not exceed a period of 2 weeks and should be reserved for moderate to severe pain. The failure to respond to a time limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. The guidelines recommend short term opiate use for acute pain, longer term use contingent upon ongoing functional improvement. The documentation provided indicates that there is no increased function noted with this extended opiate use, continuation is not medically appropriate. **the request for Hydrocodone / acetaminophen 10/325mg #135 is not medically necessary and appropriate.**

2) Regarding the request for Ketoprofen 75mg #90:

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, pg. 67, which is part of the MTUS.

Rationale for the Decision:

The requested medication, Ketoprofen is medically necessary for the treatment of the employee's pain condition. Ketoprofen is a non-steroidal anti-inflammatory medication (NSAID). These medications are recommended for the treatment of chronic pain as a second line therapy after acetaminophen. The documentation indicates the employee has significant cervical and lumbar disc disease and the medication has proved beneficial in conjunction with physical therapy and chiropractic therapy for pain control. **The request for Ketoprofen 75mg #90 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, 18th Floor
Oakland, CA 94612

/ldh

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.