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**Notice of Independent Medical Review Determination**

Dated: 8/26/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/1/2013  
Date of Injury: 3/19/2010  
IMR Application Received: 7/12/2013  
MAXIMUS Case Number: CM13-0001341

- 1) MAXIMUS Federal Services, Inc. has determined the retrospective request for 120 units of Hydrocodone (10/325 mg) **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/12/2013 disputing the Utilization Review Denial dated 7/1/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/16/2013. 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 retrospective request for 120 units of Hydrocodone (10/325 mg) **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, has a subspecialty in Pain 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.

### Case Summary:

Disclaimer: The following case summary was taken directly from the visit note by [REDACTED] dated June 17, 2013.

Mr [REDACTED] a 56 year old black/african american patient is in the office today for a follow up appointment. Patient complains of left shoulder and lower back pain. Patient rates the pain as 7/10 with zero being no pain and 10 being the worst pain possible. He denies radiation of pain to any other location. He experiences daily cycles of pain. The pain is characterized as aching and sharp. It becomes worse with reaching. Since last visit his pain level has increased moderately. He states that medications are working well. Patient may be developing medication dependency. Medication abuse is suspected. The patient states he is taking his medications as prescribed. But he feels his current pain medications are not providing adequate pain control and would like to increase dose of medications. He still has pain symptoms on a continuous basis, but they are alleviated somewhat by current meds. He understands that his symptoms will not be completely eliminated by pain medications. The patient states his condition is unchanged.

The level of functionality of the patient has stayed the same.

### 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
- Utilization Review Determination by [REDACTED] (dated 7/1/13)
- Medical Records by [REDACTED] (dated 5/8/13 to 5/28/13)
- Medical Records by [REDACTED] (dated 3/21/13)
- Preoperative History and Physical Report by [REDACTED] (dated 7/11/12)

- Imaging Report by [REDACTED] (dated 5/8/12 and 2/14/13)
- Medical Records by [REDACTED] (dated 4/30/12 to 4/24/13)
- Physical Therapy Notes by [REDACTED] (dated 7/12/12 and 11/7/12)
- Medical Records by [REDACTED], M.D. (dated 5/29/12 to 6/17/13)
- Medical Records by [REDACTED] (dated 5/29/12 to 6/17/13)
- Chronic Pain Medical Treatment Guidelines (2009) – Opioids section, pages 74-96

**1) Regarding the retrospective request for 120 units of Hydrocodone (10/325 mg):**

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

The Claims Administrator based its decision on the California Medical Treatment Utilization Schedule (MTUS), but did not list a specific citation. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer relied on the Chronic Pain Medical Treatment Guidelines, pages 76-80, which are part of the MTUS.

Rationale for the Decision:

The employee was injured on 3/19/2010 and has experienced pain in the left shoulder and low back. Treatment to date has included medications. A retrospective request for 120 units of Hydrocodone (10/325 mg) was submitted.

The MTUS Chronic Pain Guidelines list criteria for ongoing management of opioid use. Among the listed criteria are: prescriptions taken from a single practitioner and single pharmacy; lowest possible dose to improve pain and function; use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control; and documentation of misuse of medications.

The medical records submitted and reviewed show evidence of objective functional benefit from narcotic medication use. Specifically, progress is shown by the employee's ability to perform household chores and hygienic ADLs per a physician's note dated 6/17/2013. However, the physician's note also suggests the employee may be misusing and/or abusing opioids. The treatment plan submitted for review states that urine toxicology test(s) have been performed, but the results were not submitted for review. There were no records submitted to show non-aberrant toxicology screening or patient activity reports that eliminate the possibility of doctor shopping. The criteria for continued use are not satisfied. The retrospective request for 120 units of Hydrocodone (10/325 mg) 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, 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.