

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/13/2013

[REDACTED]

[REDACTED]

| | |
|---------------------------|--------------|
| Employee: | [REDACTED] |
| Claim Number: | [REDACTED] |
| Date of UR Decision: | 7/19/2013 |
| Date of Injury: | 8/15/2001 |
| IMR Application Received: | 8/5/2013 |
| MAXIMUS Case Number: | CM13-0006628 |

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Percocet 10/325MG 120 is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Butrans patches 10MCG is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Zanaflex 4MG is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/5/2013 disputing the Utilization Review Denial dated 7/19/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/27/2013. 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 **Percocet 10/325MG 120 is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Butrans patches 10MCG is medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **Zanaflex 4MG 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 employee is a 44-year-old who injured his back lifting and carrying a 36" TV while working for [REDACTED] on 8/15/01. Accepted body regions include hernia and lower back. The employee has not worked since 2001. Prior L4/5 laminectomy in 1995. Since the injury, the employee had a right inguinal hernia repair on 9/25/01, in 2003 had a lumbar laminectomy and fusion L5/S1, and in 9/25/05 the employee had the removal of the right testicle. The employee has had selective nerve root blocks (SNRBs), transforaminal epidural spinal injection (TFESI), and sacroiliac (SI) joint injections.

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 Percocet 10/325MG 120:

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 Treatment Guidelines, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 88-89, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Guidelines indicate that with long-term use of opioids, pain and functional improvement should be documented and compared to baseline and pain should be assessed at each visit, and functioning should be measured at 6-month intervals. The medical records provided for review shows evidence of documented pain levels at each visit. The medical records indicate that the employee's pain levels decreased with the use of medication. **The request for Percocet 10/325mg #120 is medically necessary and appropriate.**

2) Regarding the request for Butrans patches 10MCG:

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 Treatment Guidelines, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 26-27, 88-89, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Guidelines indicate buprenorphine (Butrans) is recommended for the treatment of opiate addiction, and is also recommended as an option for chronic pain, especially after detoxification in patients who have a history of opiate addiction. The medical records provided for review indicate that the employee is using this medication for chronic pain. The medical records also indicated that the employee's pain level decreased with the use of medications. **The request for Butrans patches 10mcg is medically necessary and appropriate.**

3) Regarding the request for Zanaflex 4MG :

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 Treatment Guidelines, which is part of the MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Muscle Relaxants for pain, page 66, which is part of the MTUS.

Rationale for the Decision:

The Chronic Pain Guidelines indicate that Zanaflex is for spasticity and unlabeled use for low back pain and states there are eight (8) studies demonstrating effectiveness for low back pain. The guidelines also recommend monitoring of the liver function at baseline, one (1), three (3), and six (6) months out. The medical records provided for review indicate that this medication has helped with the spasms in the employee's back, and that there is a decrease in pain level with medications. **The request for Zanaflex 4mg 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

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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.