

**Notice of Independent Medical Review Determination**

Dated: 12/13/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/25/2013  
Date of Injury: 9/2/2004  
IMR Application Received: 8/5/2013  
MAXIMUS Case Number: CM13-0006954

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Vicodin ES 7.5/750 mg #60 with 2 refills** is not medically necessary and appropriate.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Zyrtec 10 mg #30 with 2 refills** is not 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 7/25/2013. 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 **Vicodin ES 7.5/750 mg #60 with 2 refills** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Zyrtec 10 mg #30 with 2 refills** 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 Family Practice, and is licensed to practice in Texas. 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 66-year-old female who reported injury on 09/02/2004 after a slip and fall. The patient sustained a fracture and dislocation of the left shoulder. The patient underwent a reduction, immobilization, and physical therapy. The patient continued to have sleep difficulties at night due to pain rated at 9/10 that was reduced to 2/10 to 3/10 after medication. It was also noted the patient had allergies causing her to sneeze and aggravating the patient's shoulder pain. Physical findings included acromioclavicular tenderness to palpation in the left shoulder with decreased range of motion secondary to pain. The patient's diagnoses included a shoulder sprain/strain. The treatment plan included Vicodin extended release 7.5/750 mg 1 tablet 3 times a day for pain control and Zyrtec 10 mg 1 tablet every night as a sleep aid.

### **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 Vicodin ES 7.5/750 mg #60 with 2 refills :**

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, When to Continue Opioids, and ACOEM Guidelines, which are part of MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opioids, On-Going Management, page 78, which is a part of MTUS.

Rationale for the Decision:

MTUS Guidelines recommend the ongoing usage of opioids in chronic pain management when there is documentation of a pain assessment, assessment of side effects, increased functional benefit, and evidence of compliance to a prescribed medication schedule. The clinical documentation submitted for review does indicate that the employee receives significant pain relief as a result of the prescribed medication. The employee's pain was rated at 9/10 that was decreased to 2/10 to 3/10 with medication. However, there is no indication of significant functional benefit as a result of this medication. Additionally, there is no evidence of compliance to the prescribed medication schedule. **The request for Vicodin extended release 7.5/750 mg #60 with 2 refills is not medically necessary and appropriate.**

**2) Regarding the request for Zyrtec 10 mg #30 with 2 refills :**

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 Singapore Ministry of Health, Management of rhinosinusitis and allergic rhinitis. Singapore: Singapore Ministry of Health; 2010 Feb. 93 p. [188 references], which is not a part of MTUS.

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 RX List, The Internet Drug Index. <http://www.rxlist.com/zyrtec-drug/indications-dosage.htm>.

Rationale for the Decision:

An the drug index states Zyrtec is used to treat cold or allergy symptoms, such as sneezing, itching, watery eyes, or runny nose. It is also used to treat itching and swelling caused by hives. The clinical documentation submitted for review does provide evidence that the patient has symptoms, including sneezing. However, it is noted within the documentation that the patient is being prescribed this medication as a sleep aid. This is not a recommended use for this medication. **The request for Zyrtec 10 mg 1 tablet every night #30 with 2 refills 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,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
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