

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/12/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/24/2013
Date of Injury:	10/31/2003
IMR Application Received:	8/5/2013
MAXIMUS Case Number:	CM13-0007039

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Ultram 50 mg #90 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Percocet 10/325 mg #180 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 7/24/2013. 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 **Ultram 50 mg #90 is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Percocet 10/325 mg #180 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 Internal Medicine and is licensed to practice in New York. 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 claimant is a 46-year-old with a date of injury of 10/31/2003. Diagnoses include low back pain and neck pain. On exam the patient has reduced lumbar range of motion with spinal vertebral tenderness from L4-S1, with decreased sensation on the L4-S1 dermatome on the left worse than right and positive straight leg raising on the left. Treatment has included medical therapy, psychiatric care, chiropractic care, physical therapy, right knee surgery and injection therapy of L4-S1. The treating provider has requested Ultram 50mg #90 and Percocet 10/325mg # 180

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 Treatment Utilization Schedule (MTUS)
- Medical Records from:
 - Claims Administrator
 - Employee/Employee Representative
 - Provider

1) Regarding the request for Ultram 50 mg #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 California, pages 93-96, which is part of the MTUS.

Rationale for the Decision:

According to the MTUS Chronic Pain Guidelines, Ultram (Tramadol) is a synthetic opioid which affects the central nervous system and is indicated for the treatment of moderate to severe pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. According to the medical records provided, there has been no documentation of the medication's pain relief effectiveness and no clear documentation that the employee has responded to ongoing opioid therapy. Also according to the Chronic Pain Guidelines, there has to be certain criteria followed including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred in this case. The employee may require a multidisciplinary evaluation to determine the best approach to treatment of the chronic pain syndrome. **The request for Ultram 50 mg #90 is not medically necessary and appropriate.**

2) Regarding the request for Percocet 10/325 mg #180 :

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, pages 91 - 97, which is part of the MTUS.

Rationale for the Decision:

According to the MTUS Chronic Pain Guidelines, short-acting opioids are seen as an effective method in controlling chronic pain. These medications are often used for intermittent or breakthrough pain. The treatment of chronic pain with any opioid agent requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. According to the medical records provided, there has been no documentation of the medication's pain relief effectiveness and no clear documentation that the employee has responded to ongoing opioid therapy.

Also according to the Chronic Pain Guidelines, there has to be certain criteria followed including an ongoing review and documentation of pain relief and functional status. This does not appear to have occurred in this case. The employee has continued pain despite the continued use of short acting opioid medications. The employee may require a multidisciplinary evaluation to determine the best approach to treatment of the chronic pain syndrome. **The request for Percocet 10/325 mg #180 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
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.