

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

P.O. Box 138009

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**Notice of Independent Medical Review Determination**

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Dated: 11/13/2013

[REDACTED]  
[REDACTED]  
[REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/16/2013
Date of Injury:	11/13/2011
IMR Application Received:	8/1/2013
MAXIMUS Case Number:	CM13-0005721

- 1) MAXIMUS Federal Services, Inc. has determined the request for **medication: Relafen is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/1/2013 disputing the Utilization Review Denial dated 7/16/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/16/2013. 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 request for **medication: Relafen 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 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 claimant sustained an injury in November 2011 to the left upper extremity. The patient failed conservative therapy and underwent sub acromial decompression, rotator cuff repair and biceps tenotomy. The patient was seen by Dr. [REDACTED] her orthopedic surgeon on January 3, 2013 and noted continued right shoulder pain with limited range of motion and tender to palpation of the left shoulder. The patient was taking Tylenol as needed for pain. There was associated depression, insomnia and anxiety. Another visit on June 10, 2013 had noted similar complaints and findings. A request for Relafen was made.

### **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 medication: Relafen:**

#### 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 MTUS.

The Expert Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), NSAID, pages 67-68, which are part of the

MTUS, and the Official Disability Guidelines for NASID and Relafin, which is not part of the MTUS.

Rationale for the Decision:

According to the MTUS Chronic Pain Medical Treatment Guidelines, NSAIDs such as Relafen are recommended for osteoarthritis and acute exacerbations of chronic low back pain. The employee in this case had tried Tylenol and persisted to have shoulder pain. There was no documentation suggesting osteoarthritis or specific low back pain. There was no documentation about the length of Tylenol use, dosage, and frequency of use before ascertaining failure. According to the ODG, Relafen is off-label when used for moderate pain. The description in the notes suggest moderate pain with no scale or pain quality specifically documented. **The request for the use of Relafen is not medically necessary or 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, 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.