

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/18/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/1/2013
Date of Injury: 2/24/2011
IMR Application Received: 8/5/2013
MAXIMUS Case Number: CM13-0006508

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery 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 physician 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 disputed items/services.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 57-year-old male who reported an injury on 02/24/2011. The patient has undergone a previous left shoulder rotator cuff repair on 07/22/2011. The patient has undergone MRIs of the left shoulder on 08/17/2012 and 03/19/2013 that revealed full thickness tear of the supraspinatus and infraspinatus tendons. The most recent MRI revealed retraction and significant muscle atrophy. The patient was given prescriptions for Relafen that appears to have started on 10/22/2012. The patient had been previously taking omeprazole for prescriptions for naproxen. The AME report on 02/09/2013 reported that the most proximal 15 mm of the lateral aspect of the deltoid muscle was severely attenuated from its insertion on the acromion. The patient is noted to be carrying out a home exercise program and has physical exam findings of decreased range of motion and weakness in his left shoulder. The patient has diagnoses to include bilateral shoulder rotator cuff syndrome, failed left shoulder surgery, and lumbar disc syndrome. The patient is being recommended for left shoulder surgery with associated care, as well as medication management.

IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

- 1. One repeat left shoulder rotator cuff repair with protein rich plasma (PRP) injection is not medically necessary and appropriate.**

The Claims Administrator based its decision on the ACOEM Guidelines, Chapter 9, Shoulder Complaints, pgs. 210, 214, which is part of the MTUS and the Official Disability Guidelines (ODG), Indications for surgery, rotator cuff repair, and platelet-rich plasma, which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG), Shoulder (Acute & Chronic), Revision rotator cuff repair and platelet-rich plasma, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

The California MTUS and ACOEM Guidelines do not address this request. However, the Official Disability Guidelines state that revision rotator cuff repair is inferior to primary surgery and there should be intact deltoid origin with good quality rotator cuff tissue. Furthermore, guidelines state that platelet-rich plasma injections are under study. The documentation submitted for review indicates that the deltoid is not intact and the employee has extremely poor quality rotator cuff tissue with retraction and atrophy. Therefore, the repeat left shoulder rotator cuff repair would not be supported. **The request for one repeat left shoulder rotator cuff repair with protein rich plasma (PRP) injection is not medically necessary and appropriate.**

2. One pre-op medical clearance is not medically necessary and appropriate.

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

3. 18 post-op physical therapy is not medically necessary and appropriate.

Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

4. Omperazole 20 mg #60 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, NSAIDs, pages 66-68, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Proton-Pump Inhibitor, page 68-69, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The California MTUS Guidelines do recommend the use of omeprazole for patients at risk for gastrointestinal symptoms. The documentation submitted for review fails to indicate that the employee has any gastrointestinal symptoms. In addition, the request for Relafen was non-certified. **The request for Omperazole 20 mg #60 is not medically necessary and appropriate.**

5. Relafen 750 mg # 10 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Nabumetone (Relafen, generic available), which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, NSAIDs, pages 66-68, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The California MTUS Guidelines do recommend the use of NSAIDs at the lowest dose for the shortest amount of time. The documentation submitted for review fails to indicate that the employee has any significant, quantitative pain relief with medication regimen. Furthermore, most recent notes indicate that the employee is being recommended for naproxen and not Relafen. **The request for Relafen 750 mg #10 is not medically necessary and appropriate.**

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.

[REDACTED]

CM13-0006508