

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Independent Medical Review Final Determination Letter

[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/20/2013

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/23/2013
Date of Injury: 2/18/2009
IMR Application Received: 8/8/2013
MAXIMUS Case Number: CM13-0008602

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 Surgeon, has a subspecialty in Shoulder and Elbow Surgery and is licensed to practice in California and Utah. 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:

This claimant is a 32-year-old female with reported date of injury of 02/08/2009. The mechanism of injury is described as carrying some dirty towels and dishes with complaints of pain. She was seen for evaluation on 07/11/2012 and reported impingement and clicking with motion to the left shoulder. There is tenderness to palpation about the anterior glenoid. A labral tear was suspected. MRI dated 07/16/2012 revealed findings strongly suspicious for inferior labral tear, bony glenoid process appeared intact as did the long head of the biceps tendon. She returned to clinic after the MRI and surgery was discussed, but she pended surgery as she wanted to clarify if her cervical spine was causing any of her pain that was at that time attributable to her shoulder. Initial physical therapy evaluation, occurred on 03/13/2013, for complaints of bilateral left greater than right shoulder pain. She returned to physical therapy on 04/22/2013 and had intermittently attended 4 physical therapy sessions. An MRI of her neck, subsequently, demonstrated this to be an essentially normal for age. MRI of the cervical spine showed minimal early degenerative disc disease at C5-6 with minimal less than 1 mm posterior disc bulge centrally. No nerve root abutment. On 05/29/2013, she returned to clinic continuing to complain of left shoulder pain. She had good flexion at 180 degree and abduction was 180 degrees with external rotation at 90 degrees with internal rotation of 90 degrees. She was continued on conservative care in the form of 6 physical therapy sessions to the neck and right shoulder. Diagnoses included glenoid labral tear to the left shoulder, partial tear of the rotator cuff, impingement of the shoulder and gastritis. The treatment plan was to provide cyclobenzaprine 10 mg #30 with 5 refills, Celebrex 200 mg with 5 refills, and request repair and debridement of the glenoid labral tear and subacromial decompression of the left shoulder.

IMR DECISION(S) AND RATIONALE(S)

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

1. Cyclobenzaprine 10mg #30 with 5 refills between 7/10/2013 and 1/6/2014 is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence based criteria for its decision.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section Cyclobenzaprine, pgs. 41-42, & 63-66, which is part of MTUS.

The Physician Reviewer's decision rationale:

The MTUS Chronic Pain Guidelines indicate that Cyclobenzaprine, also known as Flexeril, are used as a skeletal muscle relaxant. The MTUS guidelines recommended Cyclobenzaprine as an option, for a short course of therapy. The guidelines also indicate that the effect is greatest in the first 4 days. The treatment should be brief, dosing is 5 mg 3 times a day and can be increased to 10 mg 3 times a day. This medication is not recommended to be used for longer than 2 to 3 weeks. The medical records submitted for review demonstrate this employee has been on this medication since at least 08/2013. The last clinical note provided for this review was 05/29/2013 and the records are silent after that date. The employee was on this medication as of 05/29/2013. As such, the current status of the employee with this medication is not stated by the records provided, but does indicate that the employee has been on this medication for at least 2 to 3 weeks. Continuation of this medication is not supported due to the length of time the employee has already been on this medication and due to lack of documentation that the employee has significant need for this medication as muscle spasms have not been documented currently as the last clinical note was 05/29/2013. Therefore, this request is not considered medically necessary and is non-certified. **The request for Cyclobenzaprine 10mg #30 with 5 refills between 7/10/2013 and 1/6/2014 is not medically necessary and appropriate.**

2. Celebrex 200MG #30 with five refills is not medically necessary and appropriate.

The Claims Administrator did not cite any evidence based criteria for its decision.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Section NSAIDs, pgs. 67-73, which is part of MTUS.

The Physician Reviewer's decision rationale:

The rationale for why the requested medical treatment is not medically necessary is that this Celebrex is a nonsteroidal anti-inflammatory medication. According to the MTUS Chronic Pain guidelines, this medication is recommended at the lowest dose for the shortest period of time in individuals with moderate/severe pain. The medical records submitted for this review indicate that the employee has been on this medication for a significant length of time, going back to at least 11/28/2012. Current status of the employee with this medication has not been demonstrated as the records are silent after 05/29/2013. There are no current lab reports indicating that this medication has not caused adverse events to the renal or kidney functions. Overall, efficacy of this medication has not been demonstrated by the records. The employee's current subjective complaints and objective findings have not been documented. The rationale for continuation of this medication has not been documented by the records provided; therefore, this request is non-certified. **The request for Celebrex 200MG #30 with five refills is not medically necessary and appropriate.**

3. Repair/debridement of glenoid labral tear and subacromial decompression of the left shoulder between 7/10/2013 and 9/8/2013 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) shoulder chapter, Section SLAP tears, which is not part of MTUS.

The Physician Reviewer based his/her decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9), pg. 210-211, which is part of MTUS; and the Official Disability Guidelines (ODG), Shoulder chapter, Section SLAP tears, which is not part of MTUS.

The Physician Reviewer's decision rationale:

Rationale for why this treatment is not medically necessary is that the records do indicate that the MRI revealed findings "strongly suspicious for inferior labral tear." There is also a partial thickness rotator cuff tear which had actually improved in appearance with less mass effect and signal perturbation. The acromion and acromioclavicular articulation appeared unchanged. There is no indication that there is significant impingement on imaging studies. The medical records provided for this review are silent after 05/29/2013; therefore, a current complete orthopedic evaluation of this employee's left shoulder has not been documented by the records provided. The MTUS/ACOEM guidelines indicate that there should be failure to increased range of motion and strength of the musculature around the shoulder even after exercise programs and there should be clear clinical imaging evidence of lesion that has been shown to benefit in both the short and long-term from surgical repair. Records indicate the employee has normal range of motion of the shoulder with flexion at 180 degrees, abduction at 180 degrees, and internal rotation at 90 degrees. In support of MTUS/ACOEM guidelines, the Official Disability Guidelines' shoulder chapter is utilized to discuss a labral repair. There should be documentation of what type of tear it is, whether it is type 1, type 2, type 3, or type 4 to indicate a medical necessity for surgical intervention to the labrum. This was not documented fully by the MRI of 07/16/2012. Records indicate the employee has only undergone 4 physical therapy visits and therefore failure of conservative measures has not been documented. The request is not supported by MTUS/ACOEM and is non-certified. **The request for Repair/debridement of glenoid labral tear and subacromial decompression of the left shoulder between 7/10/2013 and 9/8/2013 is not medically necessary and appropriate.**

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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.

[REDACTED]

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