

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Independent Medical Review Final Determination Letter**

[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/24/2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/24/2013  
Date of Injury: 5/29/2012  
IMR Application Received: 8/14/2013  
MAXIMUS Case Number: CM13-0008614

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 Physical Medicine and Rehabilitation, has a subspecialty in Sports Medicine 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 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:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

### 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 27-year-old male who reported an injury on 05/29/2012 due to pushing an office desk that weighed over 200 pounds causing a popping sensation and immediate pain in the right shoulder. The patient was initially treated with conservative therapy to include medications, physical therapy, and injections. The patient underwent an MRI that revealed tendinosis of the supraspinatus and infraspinatus and a partial thickness labral tear. The patient underwent shoulder arthroscopy, subacromial decompression, and labrum repair followed by postsurgical physical therapy. The patient continued to have right shoulder pain and significantly limited range of motion. Physical findings included limited range of motion in abduction to 30 degrees and in flexion to 30 degrees with significant tenderness along the clavicle. The patient's diagnosis included right shoulder girdle internal derangement. The patient's treatment plan included continuation of medications and a trial of spinal cord stimulation.

### IMR DECISION(S) AND RATIONALE(S)

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

**1. Trial of spinal cord stimulation for the right brachial plexus is not medically necessary and appropriate.**

The Claims Administrator based its decision on the CA MTUS, 2009, Chronic Pain Medical Treatment Guidelines, page 107, which is part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines Spinal Cord Stimulator, page 105, which is part of MTUS.

The Physician Reviewer's decision rationale:

The requested trial of spinal cord stimulation for the right brachial plexus is not medically necessary or appropriate. The employee does have persistent right shoulder pain complaints and significantly limited range of motion that is recalcitrant to conservative therapy. The CA MTUS recommends spinal cord stimulator trial for patients who have failed back surgery syndrome and complex regional pain syndrome type 1. The clinical documentation submitted for review does not provide evidence that the employee has either one of these diagnoses. Additionally, a trial for a spinal cord stimulator must be supported by a psychological evaluation. The clinical documentation submitted for review did not include a psychological evaluation. **The request for a trial of spinal cord stimulation for the right brachial plexus is not medically necessary or appropriate.**

/cm

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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