

**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: 7/22/2013  
Date of Injury: 2/18/2008  
IMR Application Received: 8/8/2013  
MAXIMUS Case Number: CM13-0008943

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 Internal 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:

- [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 female injured on 02/18/2008. The patient's most recent clinical records are from 08/27/2012 when she saw [REDACTED], MD for complaints of inability to sleep due to right shoulder pain that was rated at 5/10 on a VAS score and left knee pain rated 8/10 on the VAS score. She was noted to be status post prior right shoulder surgery in 02/2013 in the form of an arthroscopy. She is also status post a 12/14/2012 left total knee replacement procedure with manipulation under anesthesia performed 12 days prior on 08/15/2013. Physical examination findings showed 0 degrees to 120 degrees range of motion on the right knee with the left knee status post manipulation at 20 degrees to 80 degrees. Pain was noted in all planes of motion. There was 5-/5 strength to the right lower extremity and 4/5 strength with knee extension and 5-/5 strength with remainder of left lower extremity evaluation. Shoulder examination was not performed. She was given diagnoses of status post right shoulder arthroscopy, status post left total knee arthroplasty with manipulation, and insomnia. Medications were recommended in the form of Norco, Prilosec, and Relafen, in addition to a course of physical therapy for the knee. A prescription was also given for a "topical cream;" however, components of this topical agent were not documented. The request in this case also indicates a prescription for cyclobenzaprine for the patient.

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

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

**1. Prilosec (Omeprazole) 20mg #90 capsules is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, pages 68-69, which are part of the MTUS.

The Physician Reviewer's decision rationale:

Based on California MTUS, Chronic Pain Medical Treatment Guidelines, omeprazole would not be supported. While the patient is noted to be status post total knee replacement surgery and recent manipulation under anesthesia, there is no current indication of GI risk factor that would support the role of omeprazole in this case. In absence of GI risk factors which would include an age greater than 65 years, concordant use of aspirin, steroid, or high dose anti-inflammatory agents, history of peptic ulcer, GI bleeding, or perforation, or multiple high dose non-steroid use, the recommendations for the agent would not be indicated.

**2. Flexeril (Cyclobenzaprien) 7.5mg #90 is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, page 41, which is part of the MTUS.

The Physician Reviewer's decision rationale:

Based on California MTUS, Chronic Pain Medical Treatment Guidelines, cyclobenzaprine would not be supported. Guidelines recommend the role of cyclobenzaprine as a short-term use for therapy. It is indicated that efficacy is greatest in the first 4 days of treatment, but the role of any muscle relaxant for greater than a 4 weeks period of time is not supported. While the records indicate the patient is status post a recent manipulation under anesthesia to the knee in early 08/2013, she would now be 5 months from the time of this procedure. This time frame would not support the continued role of muscle relaxant agents that as stated are only indicated for short-term use. At recent clinical assessment, physical examination findings for the patient's shoulder were not present. There would also not be indication for use of muscle relaxant for the patient's continued diagnosis of "status post shoulder arthroscopy" in this case as well.

**3. Topical cream is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, page 111, which is part of the MTUS.

The Physician Reviewer's decision rationale:

Based California MTUS, Chronic Pain Medical Treatment Guidelines topical cream would not be supported. Topical cream is a vague term with no indication of agents that are being utilized in the cream or indication as to where the cream would be utilized. The vagueness of the statement as a whole would not support clinical guidelines which strongly do not recommend the role of certain agents based on specific medication makeup. California MTUS, Chronic Pain Management Treatment Guidelines do not support the role of compounded agents if any 1 agent is not supported. The specific request for "topical cream" without indication of known medication would not be supported.

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.



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