MAXIMUS FEDERAL SERVICES, INC.
Independent Medical Review
P.O. Box 138009
Sacramento, CA 95813-8009
(855) 865-8873 Fax: (916) 605-4270

MAXIMUS Federal Services

Independent Medical Review Final Determination Letter

Dated: 12/18/2013

Employee:	
Claim Number:	
Date of UR Decision:	7/25/2013
Date of Injury:	2/15/2006
IMR Application Received:	8/16/2013
MAXIMUS Case Number:	CM13-0013447

DEAR

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,

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 Anesthesiology, has a subspecialty certificate in Fellowship Trained in Pain 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, employee/employee representative, Provider)
- 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 71-year-old male who reported an injury on 02/15/2006 due to a fall. The patient was treated conservatively with physical therapy and medications. The patient underwent shoulder surgery in 07/2006 and then again in 02/2012. Conservative treatments included acupuncture, topical creams, and injections to the right elbow. An MRI of the right shoulder revealed thinning and postoperative changes, changes from an acromioplasty and prominent degenerative changes of the distal end of the clavicle, and no evidence of a labral tear. The patient's diagnoses included a cervical strain with disc lesion and associated radiculopathy, right wrist internal derangement, status post right shoulder arthroscopy. The patient's treatment plan included a second cervical epidural steroid injection and a second steroid injection to the right shoulder.

IMR DECISION(S) AND RATIONALE(S)

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

1. Cervical facet epidural steroid injection #2 is not medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Epidural Steroid Injection (ESI), pg. 46, which is part of the MTUS.

The Physician Reviewer's decision rationale:
The employee has continued cervical spine pain. The employee previously received and epidural steroid injection. California Medical Treatment Utilization Schedule states repeat blocks should be based on continued functional benefit and a resolution of pain of at least 50% with associated

reduction in medications for 6 to 8 weeks. The clinical documentation submitted for review does not provide any evidence of functional benefit or reduction in pain medications as a result of the prior cervical epidural steroid injection. It is noted that the employee had 50% pain relief as a result of that injection; however, the duration was not addressed. Additionally, the most recent clinical evaluation does not provide evidence of radiculopathy to support the need for an additional injection. **The request for cervical facet epidural steroid injection #2 is not medically necessary and appropriate.**

2. Right shoulder AC joint injection #2 is not medically necessary and appropriate.

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

The Physician Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Shoulder Complaints, Chapter 9, pgs. 211-214, which are part of the MTUS.

The Physician Reviewer's decision rationale:
The employee does have shoulder and cervical pain. Documentation does indicate that the employee received a prior steroid injection to the right shoulder. The American College of Occupational and Environmental Medicine does recommend 2 to 3 subacromial injections of local anesthetic for an extended period as part of an exercise rehabilitation program. However, documentation does indicate that the employee received an injection in 06/2013. Clinical note dated 07/02/2013 did not provide evidence of adequate pain resolution, functional benefit as result of the injection. **The request for right shoulder AC joint injection #2 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]

CM13-0013447