

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review  
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**Independent Medical Review Final Determination Letter**

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/18/2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 8/6/2013  
Date of Injury: 5/18/2009  
IMR Application Received: 8/20/2013  
MAXIMUS Case Number: CM13-0014294

DEAR [REDACTED] Attorneys at Law,

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in California and 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:

- 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 59 year old female who reported an injury on 05/18/2009 to her neck, bilateral shoulders, and bilateral wrists caused by repetitive work. She underwent electromyography (EMG) /nerve conduction velocity (NCV) studies of the upper extremities which revealed no abnormalities. She also had an epidural steroid injection to her cervical spine. A second EMG /NCV revealed bilateral carpal tunnel syndrome. The patient completed some physical therapy and was treated with oral anti-inflammatories to help alleviate the discomfort. MRI's of her bilateral shoulders revealed a small tear of the supraspinatus tendon with subacromial and subdeltoid bursitis of the right shoulder; and the thinning of the supraspinatus tendon at the insertion site with abnormal signal, consistent with at least a partial tear, subacromial and subdeltoid bursitis, and small joint effusion of the left shoulder. The patient underwent shoulder surgery on 10/15/2010 which consisted of a subacromial decompression, acromioplasty, distal clavicle resection, and debridement of the rotator cuff re-tear followed by a subsequent surgery was performed on 05/27/2011 to include decompression with coracoacromial ligament resection, bursal resection, glenohumeral synovectomy, chondroplasty, distal clavicle resection, and a debridement of the labrum and a partial rotator cuff tear. The most recent clinical note dated 08/27/2013 revealed the patient had tenderness and spasm in bilateral trapezius and parascapular regions along with decreased range of motion of the bilateral shoulder.

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

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

#### **1. Error! Reference source not found.is not medically necessary and appropriate.**

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

The Physician Reviewer based his/her decision on The Chronic Pain Medical Treatment Guidelines, Botox and Trigger Point Injections, pages 25, 122, which is part of MTUS.

The Physician Reviewer's decision rationale:

The CA MTUS state Botox is not generally recommended for chronic pain disorders but recommended for cervical dystonia. The CA MTUS indicates trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when there is (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, non-steroidal anti-inflammatory drugs (NSAID's) and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. The CA MTUS further states Botox is not recommended for myofascial pain syndrome and trigger point injections. Based on the medical records reviewed the requested treatment is not supported for the employee's condition. **The request for Error! Reference source not found.is not medically necessary.**

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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]