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**Notice of Independent Medical Review Determination**

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- 1) MAXIMUS Federal Services, Inc. has determined the requested cold therapy unit (duration unspecified) **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 4/24/2013 disputing the Utilization Review Denial dated 4/15/2013. A Notice of Assignment and Request for Information was provided to the above parties on 6/27/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the requested cold therapy unit (duration unspecified) **is not medically necessary and appropriate.**

### **Medical Qualifications of the Expert Reviewer:**

The independent Medical Doctor who made the decision 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 Expert 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 treatments and/or services at issue.

### **Case Summary:**

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated April 15, 2013

“This is a 52-year-old female with a 2/10/2013 date of injury; when she was flipping a king size duvet cover. 3/18/13 progress report indicates persistent right shoulder pain for 5 weeks. She notes increased pain with any attempted overhead activity. She has also described weakness. Physical exam demonstrates right shoulder enervation weakness, limited right shoulder enervation, positive Neer and Hawkins tests. 2/11/13 right shoulder x-ray demonstrates well-maintained joint space with minimal degenerative changes of the AC joint.”

### **Documents Reviewed for Determination:**

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application for Independent Medical Review (dated 4/24/2013)
- Utilization Review by [REDACTED] (dated 4/15/2013)
- Employee Medical Records from [REDACTED] (dated 2/11/13, 2/19/13, 3/5/13, 4/4/13, 5/16/13, 6/26/13)
- Employee Medical Records from [REDACTED] (dated 2/27/13)
- Employee Medical Records from [REDACTED], MD (dated 3/18/13 and 6/15/13)
- Request for Authorization for Medical Treatment (DWC Form RFA) (dated 3/20/13)
- Employee Medical Records from [REDACTED] (dated 5/7/13)
- Employee Medical Records from [REDACTED] (dated 5/24/13)
- Employee Medical Records from [REDACTED] (dated 6/5/13)
- Request for Authorization for Medical Treatment (DWC Form RFA) (dated 6/28/13)
- ODG Guidelines Treatments (Procedure Summaries): Chapter 6 Shoulder Cryotherapy

### **1) Regarding the request for cold therapy unit (duration unspecified) :**

#### Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the Official Disability Guidelines (ODG) (2009) Chapter 6, Shoulder Cryotherapy, which is not part of the Medical Treatment Utilization Schedule (MTUS) Guidelines. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found that the MTUS did not apply to the issue at dispute and based his/her decision on the ODG (May 2009) Chapter 6, Shoulder Cryotherapy.

#### Rationale for the Decision:

The employee was involved in a work-related injury on 2/12/2013 which resulted in a right shoulder injury. The medical records provided for review indicate surgery was performed on 5/7/2013 which included a right open rotator cuff repair, right open acromioplasty, and a right diagnostic shoulder arthroscopy.

MTUS does not specifically address cold therapy packs, therefore the Official Disability Guidelines (ODG) were referenced. ODG states that postoperative use of continuous-flow cryotherapy units generally may be up to 7 days, including home use. There is no evidence in the guidelines for use after the initial 7 days nor do the guidelines recommend an unspecified duration. Cold therapy unit (unspecified duration) **is not medically necessary and appropriate.**

**Effect of the Decision:**

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely;

Richard C. Weiss, MD, MPH, MMM, PMP  
Medical Director

cc: Department of Industrial Relations  
Division of Workers' Compensation  
1515 Clay Street, 18<sup>th</sup> Floor  
Oakland, CA 94612

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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.



