
Independent Medical Review Final Determination Letter

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Dated: 12/31/2013

IMR Case Number:	CM13-0012248	Date of Injury:	12/17/2010
Claims Number:	██████████	UR Denial Date:	07/24/2013
Priority:	Standard	Application Received:	08/20/2013
Employee Name:	██████████		
Provider Name:	██████████		
Treatment(s) in Dispute Listed on IMR Application:	Cold therapy unit rental for seven days		

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: OVERTURN. This means we decided that all 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 PM&R, and is licensed to practice in Pennsylvania. 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 underlying date of injury in this case is 12/17/2010. This patient's treating diagnoses include visual dysfunction, headaches, right shoulder severe impingement syndrome, and multilevel cervical disc protrusions with degenerative disc disease.

An initial physician review modified a request for a right shoulder arthroscopy with open rotator cuff repair and subacromial decompression. That reviewer reviewed the contents of the Official Disability Guidelines and noted that the available scientific literature is insufficient to document the use of continuous-flow cooling systems associated with a benefit beyond convenience and patient compliance.

IMR DECISION(S) AND RATIONALE(S)

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

1. Cold therapy unit rental for seven days is medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Chapters Cervical, Lumbar, Shoulder and Knee, which is not part of the MTUS.

The Physician Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer based his/her decision on the Official Disability Guidelines (ODG), Treatment of Workers' Compensation/Shoulder, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

Official Disability Guidelines/Treatment of Workers' Compensation/Shoulder states regarding continuous-flow cryotherapy, "Recommended as an option after surgery, but not for nonsurgical treatment...Postoperative use generally may be up to 7 days...In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage." This treatment, therefore, is specifically supported by the treatment guidelines. The rationale in an initial physician review that this treatment is considered really for patient convenience is not supported by treatment guidelines. This request is medically necessary.

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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