

## Independent Medical Review Final Determination Letter

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Dated: 12/31/2013

<b>IMR Case Number:</b>	CM13-0017832	<b>Date of Injury:</b>	11/22/2012
<b>Claims Number:</b>	[REDACTED]	<b>UR Denial Date:</b>	08/08/2013
<b>Priority:</b>	STANDARD	<b>Application Received:</b>	08/28/2013
<b>Employee Name:</b>	[REDACTED]		
<b>Provider Name:</b>	[REDACTED] M.D.		
<b>Treatment(s) in Dispute Listed on IMR Application:</b>			
Q-TECH RECOVERY SYSTEM WITH WRAP E1399, E0655, E0249 21 DAY RENTAL			

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 Orthopedic Surgery, has a subspecialty in Reconstructive Surgery 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 46-year-old male who reported an injury on 11/22/2012. The patient was seen in the emergency room on the date of injury status post motor vehicle accident. The patient ultimately underwent an MRI of the right shoulder that revealed a full thickness supraspinatus tendon tear and moderate hypertrophic changes of the AC joint. On 06/14/2013, the patient underwent left shoulder arthroscopic synovectomy, bursectomy, subacromial decompression, rotator cuff repair, coracoacromial ligament resection, and subacromial bursa resection. Postoperatively, the patient participated in physical therapy and had pain complaints. As of 06/20/2013, the patient had clean and dry incision with no erythema, drainage, or infection. On 08/15/2013, the patient was noted to have improving symptoms with 175 degrees of flexion, 45 degrees of external rotation, and internal rotation to T6. The patient utilized Q-T recovery system for 21 days postoperatively.

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

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

### **1. Q-Tech recovery system with wrap E1399, E0655, E0249 21 day rental is not medically necessary and appropriate.**

The Claims Administrator based its decision on the Shoulder Complaints Chapter, ACOEM Guidelines, 2<sup>nd</sup> Edition, 2008 pages 561-563 which is part of the MTUS, and the Official Disability Guidelines Shoulder Chapter, section on Continuous-flow Cryotherapy, 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 Physician Reviewer based his/her decision on the Official Disability Guidelines Shoulder Chapter, section on Continuous-flow Cryotherapy.

The Physician Reviewer's decision rationale:

Official Disability Guidelines state that continuous flow cryotherapy is recommended as an option after surgery but is generally recommended for 7 days including home use. The current request is for a 21 day rental of a continuous flow cryotherapy unit. The request exceeds evidence based guidelines for total duration of care. The documentation submitted for review does not provide any exceptional factors to warrant the 2 week excess of guideline recommendations. **The request for Q-Tech recovery system with wrap E1399, E0655, E0249 21 day rental is not medically necessary and appropriate.**

### /MCC

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[REDACTED]

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