

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

Dated: 12/12/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	8/22/2013
Date of Injury:	1/14/2009
IMR Application Received:	8/28/2013
MAXIMUS Case Number:	CM13-0017948

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Q-Tech recovery system with wrap, 21 day rental is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **half arm wrap and universal therapy wrap purchase is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **programmable pain pump purchase is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/28/2013 disputing the Utilization Review Denial dated 8/22/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. 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 request for **Q-Tech recovery system with wrap, 21 day rental is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **half arm wrap and universal therapy wrap purchase is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **programmable pain pump purchase 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 Orthopedic Surgery and is licensed to practice in Minnesota, Nebraska, 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 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.

### **Expert Reviewer Case Summary:**

The patient is a 53-year-old female who was noted to have undergone surgery for a torn rotator cuff on 07/30/2013. The treatment was noted to have requested a Q-Tech recovery system with wrap, a half arm wrap and universal therapy wrap, and a programmable pain pump.

### **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 of Independent Medical Review
- Utilization Review Determination
- Medical Treatment Utilization Schedule (MTUS)
- Medical Records from:
  - Claims Administrator
  - Employee/Employee Representative
  - Provider

**1) Regarding the request for Q-Tech recovery system with wrap, 21 day rental:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, which is part of the MTUS, and Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 9), pg. 203, which is part of the MTUS.

The Expert 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), Shoulder Chapter, Continuous Flow Cryotherapy, and Knee & Leg Chapter, (Online Version), which are not part of MTUS.

Rationale for the Decision:

Official Disability Guidelines (ODG) recommend continuous-flow cryotherapy for up to a 7 days rental postoperatively. The ODG address deep vein thrombosis (DVT) and indicate that that individuals at high risk of developing deep venous thrombosis should be identified and should be provided prophylactic measures as necessary. The clinical documentation submitted for review while indicating the physician requested the Q-Tech recovery system, failed to provide the necessity for the 21 day rental. The clinical documentation failed to provide that the employee had been assessed for high risk for deep vein thrombosis. In addition, the documentation failed to provide the rationale that the employee would not benefit from oral prophylactic measures, if necessary. Given the above, the request is not recommended. **The request for Q-Tech recovery system with wrap, 21 days rental is not medically necessary and appropriate.**

**2) Regarding the request for half arm wrap and universal therapy wrap purchase:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert 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), Shoulder Chapter, Continuous Flow Cryotherapy, and Knee & Leg Chapter, (Online Version), which are not part of MTUS.

Rationale for the Decision:

Given that the request for the Q-Tech recovery system was not supported, the request for a half arm wrap and universal therapy wrap purchase would not be supported. **The request for half arm wrap and universal therapy wrap purchase is not medically necessary and appropriate.**

**3) Regarding the request for a programmable pain pump purchase:**

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Use of Pain pumps Tied to Knee Chondrolysis (American Academy of Orthopaedic Surgeons (AAOE)), (2012), which is not part of MTUS.

The Expert 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), Shoulder Chapter, Postoperative Pain Pump, which is not part of MTUS.

Rationale for the Decision:

The Official Disability Guidelines (ODG) do not recommend a postoperative pain pump if there is insufficient evidence to conclude that direct infusion is more effective than conventional postoperative pain control using oral intramuscular or intravenous measures. The clinical documentation submitted for review noted that the physician requested a programmable pain pump for the employee postoperatively to the shoulder surgery. However, the clinical documentation failed to provide exceptional factors to support non-adherence to the guidelines recommendation. Given the above, the request for a programmable pain pump purchase is not supported. **The request for programmable pain pump purchase 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,

Paul Manchester, MD, MPH  
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.