

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/9/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 7/11/2013
Date of Injury: 11/14/2011
IMR Application Received: 7/19/2013
MAXIMUS Case Number: CM13-0002182

- 1) MAXIMUS Federal Services, Inc. has determined the request for **Don Joy iceman clear cube, cold pad** is not medically necessary and appropriate.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Bledsoe ARC shoulder brace** is not medically necessary and appropriate.

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/19/2013 disputing the Utilization Review Denial dated 7/11/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/23/2013. 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 **Don Joy iceman clear cube, cold pad** is not **medically necessary and appropriate**.
- 2) MAXIMUS Federal Services, Inc. has determined the request for **Bledsoe ARC shoulder brace** 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, has a subspecialty in Sports 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.

Expert Reviewer Case Summary:

The patient is a 41-year-old female who reported a work-related injury on 11/01/2011 as the result of a strain to the left shoulder. Subsequently, the patient underwent a left shoulder arthroscopic subacromial decompression, debridement of a partial thickness rotator cuff tear, partial distal claviclectomy, synovectomy/bursectomy under the care of Dr. [REDACTED]. A DME authorization request dated 06/10/2013 requested the purchase of a Don Joy Iceman Clear Cube cold pad as well as a Bledsoe ARC shoulder brace postoperatively for the patient.

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 Records from Employee/Employee Representative
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for Don Joy iceman clear cube, cold pad :

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 ACOEM Chapter 9, pgs. 212-214, table 9-6. Physical Treatment Methods, 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 Guideline (ODG), Shoulder Chapter, Online Edition, Continuous-flow cryotherapy.

Rationale for the Decision:

Based on the medical records provided for review the employee is a 41-year-old female who reported a work-related injury on 11/01/2011 as the result of a strain to the left shoulder. Subsequently, the employee underwent a left shoulder arthroscopic subacromial decompression, debridement of a partial thickness rotator cuff tear, partial distal claviclectomy, synovectomy/bursectomy under the care of [REDACTED]. A durable medical equipment (DME) authorization request dated 06/10/2013 requested the purchase of a Don Joy Iceman Clear Cube cold pad as well as a Bledsoe ARC shoulder brace postoperatively for the employee. The current request previously received an adverse determination on 07/11/2013 due to no medical rationale provided for a costly cold therapy unit/compression unit after a routine shoulder scope. The previous adverse determination noted that the home application of ice/cold packs would suffice for edema control. Therefore, it was found that the requested durable medical equipment was not medically necessary. The Official Disability Guidelines indicate "continuous flow cryotherapy is recommended as an option after surgery for up to 7 days." However, the current request is for the purchase of this modality. Therefore, the current request is not supported. **The request for a Don Joy Iceman Clear Cube cold pad is not medically necessary or appropriate.**

2) Regarding the request for Bledsoe ARC shoulder brace :

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 The Claims Administrator based its decision on the Official Disability Guideline (ODG), Post Op Pillow Sling, and Official Disability Guideline (ODG), Shoulder Chapter, Postoperative abduction pillow sling, which is not 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 Guideline (ODG), Shoulder Chapter, Postoperative abduction pillow sling and Immobilization.

Rationale for the Decision:

Based on the medical records provided for review the employee is a 41-year-old female who reported a work-related injury on 11/01/2011 as the result of a strain to the left shoulder. Subsequently, the employee underwent a left shoulder arthroscopic subacromial decompression, debridement of a partial thickness rotator cuff tear, partial distal claviclectomy, synovectomy/bursectomy under the care of [REDACTED]. A durable medical equipment (DME) authorization request dated 06/10/2013 requested the purchase of a Don Joy Iceman Clear Cube cold pad as well as a Bledsoe ARC shoulder brace postoperatively for the employee. The current request previously received an adverse determination on 07/11/2013 due to the claimant not falling into the accepted criteria for the utilization of a sling/abduction pillow as guidelines support that this is indicated only after the repair of large rotator cuffs per the previous adverse determination. Therefore, the request was not supported. The Official Disability Guidelines indicate, "The sling/abduction pillow keeps the arm in a position that takes tension of the repaired tendon." The employee presents status post arthroscopic subacromial decompression and debridement of the left shoulder which would not be indicated for a brace postoperatively. **The request for a Bledsoe ARC shoulder brace is not medically necessary or 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, 18th 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.