
Notice of Independent Medical Review Determination

Dated: 10/15/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/17/2013
Date of Injury:	2/22/2011
IMR Application Received:	7/23/2013
MAXIMUS Case Number:	CM13-0002780

- 1) MAXIMUS Federal Services, Inc. has determined the request for a cold therapy unit **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/23/2013 disputing the Utilization Review Denial dated 7/17/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/30/2013. 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 a cold therapy unit **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 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 July 17, 2013.

According to the clinical documentation, the patient is a 57-year-old individual who sustained an injury on 02/22/11. The mechanism of injury was not documented in the submitted clinical records. According to the Visit Note on 06/24/13 by [REDACTED] MD, patient complained of continued pain despite previous surgery. Name, dose, and scheduled use of the medication were not documented. On examination of the shoulder, Speed's test was positive. Reverse O'Brien's test was positive with pain along the bicipital groove. Range of motion (ROM) passively and actively was full. Cuff strength was 4+/5 with discomfort. Relocation test and Spurling's test were negative. Lhermitte's sign was negative with axial neck pain. Magnetic resonance imaging (MRI) of the left shoulder dated 06/12/13 interpreted by [REDACTED] DO, documented that in the acromioclavicular joint, there was a surgical change from prior subacromial decompression. There were no significant lateral down sloping and os acromiale. In glenohumeral joint, there were surgical anchors from prior labral repair. There

was fissuring of the anterior superior labrum that had progressed from the prior exam. The biceps labral anchor was intact. In rotator cuff, the rotator cuff was watertight. There was mild tendinopathy along the bursal surface of the distal supraspinatus. There was degenerative change and subchondral cyst formation in the humeral head at the infraspinatus attachment. The long head of the bicep tendon was intact. There was no evidence for nerve entrapment. MR Arthrogram of left shoulder dated 06/12/13 interpreted by [REDACTED] DO, documented that there was no evident rotator cuff tear. There was no significant degenerative change. Patient was status post left shoulder arthroscopy, lysis of adhesions, anterior capsular release and labral Bankart repair on 06/06/12 by [REDACTED] MD. Previous treatment included cortisone injection, and post-operative physical therapy with continued pain in the shoulder despite modified activities and home exercise program (HEP). The number of completed physical therapy visits and response were not documented in the clinical records submitted with this request. Treatment plans included arthroscopic biceps tenodesis, lysis of adhesions,

evaluation of the rotator cuff and possible repair and a follow-up pre-operative appointment. Patient was diagnosed with sprains and strains of other specified sites of shoulder and upper arm (840.8); and superior glenoid labrum lesion (840.7). This is a review for the medical necessity of left shoulder arthroscopy biceps tenodesis, lysis of adhesions, evaluation of the rotator cuff and possible repair, assistant physician, cold therapy unit, sling, preoperative test to include an electrocardiogram (EKG) and chest x-ray, preoperative labs to include a comprehensive metabolic panel, partial thromboplastin time, urinalysis and medical clearance.

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 (received 7/18/13)
- Utilization Review Determination from [REDACTED] (dated 7/17/2013)
- Employee medical records from the claims administrator
- Medical Treatment Utilization Schedule

1) Regarding the request for a cold therapy unit:

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), Shoulder Chapter, Continuous Flow Cryotherapy section, which is a medical treatment guideline that is not part of the California Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer determined the MTUS does not address the issue at dispute. The Expert Reviewer found the guideline used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee sustained a work-related injury on 2/22/2011. The employee is status post left shoulder arthroscopy. The request is for a cold therapy unit.

The ODG indicates continuous flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. The employee was noted to have received authorization to undergo a left shoulder arthroscopy, biceps tenodesis, lysis of adhesions, evaluation of the rotator cuff and possible repair. Although guidelines do recommend a cold therapy unit for a 7 day rental following shoulder surgery, the request does not specify duration of time that the unit is requested nor does the request indicate if the unit is for rental or purchase. The request for a cold therapy unit **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, 18th Floor
Oakland, CA 94612

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