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**Notice of Independent Medical Review Determination**

Dated: 10/17/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/15/2013  
Date of Injury: 2/10/2012  
IMR Application Received: 7/25/2013  
MAXIMUS Case Number: CM13-0003333

- 1) MAXIMUS Federal Services, Inc. has determined the request for shoulder sling with abduction pillow **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for CPM machine **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for thermocool hot and cold contrast therapy with compression **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for combo care 4 electrotherapy **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/25/2013 disputing the Utilization Review Denial dated 7/15/2013. 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 shoulder sling with abduction pillow **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for CPM machine **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for thermocool hot and cold contrast therapy with compression **is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for combo care 4 electrotherapy **is not medically necessary and appropriate.**

### Medical Qualifications of the Expert Reviewer:

The 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 Physical Medicine and Rehabilitation, 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 15, 2013:

#### History of Condition:

This is a 47-year-old female with a 2/10/2012 date of injury. A specific mechanism of injury has not been described. 10/25/12 progress report indicates minimal left shoulder pain and the pain is only with overdue shoulder movements and flexion, abduction, and extension. Physical exam demonstrates normal range of motion, but painful at the end ranges of flexion, abduction, and extension. Strength is minimally decreased compared to the right side. 5/2/12 left shoulder MRI demonstrates mostly unremarkable findings. 5/17/12 FCE report indicates lifting ability of 18.5 pounds from floor to knuckle level. 9/12/12 electromyogram report indicates unremarkable findings. 6/12/13 progress report indicates worsening left shoulder pain and weakness. Physical exam demonstrates left shoulder tenderness, positive Neer and Hawkins signs, tenderness at the AC joint with positive crossarm testing, forward flexion and

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abduction of 140 degrees. 4/29/13 left shoulder MRI demonstrates a type II acromion, AC joint synovial hypertrophy, and tendinopathy of the supraspinatus tendon. Steroid injection to the left shoulder subacromial space resulted in one week of pain reduction. Treatment to date has also included physical therapy and medication.

### 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 7/25/13)

- Utilization Review Determination from [REDACTED] (dated 7/15/13)
- Medical Records from [REDACTED]
- Medical Treatment Utilization Schedule (MTUS)

**1) Regarding the request for a shoulder sling with abduction pillow:**

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) (current version), Shoulder Chapter, a medical treatment guideline (MTG) not part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found no section of the MTUS relevant and applicable to the issue at dispute. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee injured the left shoulder in an accident on 2/10/2012. The submitted and reviewed medical records indicate that the employee has had an EMG, MRI, steroid injection, physical therapy, medications, and left shoulder surgery. The most recent medical report dated 6/12/2013 indicated that the employee was having worsening left shoulder pain and weakness. A request was submitted for a shoulder sling with abduction pillow, a continuous passive motion (CPM) machine, thermocool hot and cold contrast therapy with compression, and combo care 4 electrotherapy.

The Official Disability guidelines recommend a shoulder sling with abduction pillow following open repair of large rotator tears but not for arthroscopic repairs. The orthopedic surgical consultation, dated 6/12/2013 noted that left shoulder diagnostic and operative arthroscopy was recommended for the patient due to impingement potential and tendonopathy. The request for a shoulder sling with abduction pillow **is not medically necessary and appropriate.**

**2) Regarding the request for CPM machine:**

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) (current version), Shoulder Chapter, CPM, a medical treatment guideline (MTG) not part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found no section of the MTUS relevant and applicable to the issue at dispute. The Expert Reviewer found the guidelines used by the Claims Administrator relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee injured the left shoulder in an accident on 2/10/2012. The submitted and reviewed medical records indicate that the employee has had an EMG, MRI, steroid injection, physical therapy, medications, and left shoulder surgery. The most recent medical report dated 6/12/2013 indicated that the

employee was having worsening left shoulder pain and weakness. A request was submitted for a shoulder sling with abduction pillow, a continuous passive motion (CPM) machine, thermocool hot and cold contrast therapy with compression, and combo care 4 electrotherapy.

The Official Disability guidelines recommend continuous passive motion (CPM) for adhesive capsulitis but not for shoulder rotator cuff problems. The orthopedic surgical consultation, dated 6/12/2013, noted that left shoulder diagnostic and operative arthroscopy was recommended for the patient due to impingement potential and tendonopathy. The requested device is not supported by the guidelines. The request for a CPM machine **is not medically necessary and appropriate.**

### **3) Regarding the request thermocool hot and cold contrast therapy with compression:**

#### 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), Current Version, Knee Chapter, Continuous Flow Cryotherapy, a medical treatment guideline (MTG) not part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found no section of the MTUS relevant and applicable to the issue at dispute. The Expert Reviewer found the ODG, Shoulder Section, Continuous Flow Cryotherapy, relevant and appropriate for the employee's clinical circumstance.

#### Rationale for the Decision:

The employee injured the left shoulder in an accident on 2/10/2012. The submitted and reviewed medical records indicate that the employee has had an EMG, MRI, steroid injection, physical therapy, medications, and left shoulder surgery. The most recent medical report dated 6/12/2013 indicated that the employee was having worsening left shoulder pain and weakness. A request was submitted for a shoulder sling with abduction pillow, a continuous passive motion (CPM) machine, thermocool hot and cold contrast therapy with compression, and combo care 4 electrotherapy.

The Official Disability guidelines recommend postoperative continuous-flow cryotherapy up to 7 days. The Game Ready system combines continuous-flow cryotherapy with the use of vaso-compression. The medical records indicate that the request is for hot and cold contrast therapy with compression, which is not supported by the guidelines. The request for thermocool hot and cold contrast therapy with compression **is not medically necessary and appropriate.**

### **4) Regarding the request combo care 4 electrotherapy:**

#### Medical Treatment Guideline(s) Relied Upon by the Expert Reviewer to Make His/Her Decision:

The Claims Administrator based its decision on the California Medical Treatment Utilization Schedule (MTUS), no page cited, the Official Disability Guidelines

(ODG), Current Version, Pain Chapter, a medical treatment guideline (MTG) not part of the MTUS, and the Chronic Pain Disorder Medical Treatment Guidelines of Colorado, not part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines, transcutaneous electrotherapy, pages 114-121 and 127, part of the MTUS, relevant and appropriate for the employee's clinical circumstance.

Rationale for the Decision:

The employee injured the left shoulder in an accident on 2/10/2012. The submitted and reviewed medical records indicate that the employee has had an EMG, MRI, steroid injection, physical therapy, medications, and left shoulder surgery. The most recent medical report dated 6/12/2013 indicated that the employee was having worsening left shoulder pain and weakness. A request was submitted for a shoulder sling with abduction pillow, a continuous passive motion (CPM) machine, thermocool hot and cold contrast therapy with compression, and combo care 4 electrotherapy.

MTUS Chronic Pain Guidelines note that a TENS unit is recommended as a treatment option for acute post-operative pain in the first 30 days post-surgery. Unfortunately the same recommendation is not made for the other 3 modalities provided by the ComboCare 4 device (interferential, NMS/EMS, and syncopeation). Authorization is not recommended. The request for combo-care 4-electrotherapy **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, 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.