

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 11/18/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/9/2013
Date of Injury:	2/18/2009
IMR Application Received:	7/25/2013
MAXIMUS Case Number:	CM13-0003417

- 1) MAXIMUS Federal Services, Inc. has determined the request for **O tech recovery system (hot/cold compression DVT) 35 day rental home use** is **not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **half warm wrap, purchase** is **not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **universal therapy wrap for purchase** is **not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **shoulder CPM unit rental** 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 7/9/2013. A Notice of Assignment and Request for Information was provided to the above parties on 7/31/2013. 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 **O tech recovery system (hot/cold compression DVT) 35 day rental home use** is **not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **half warm wrap, purchase** is **not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **universal therapy wrap for purchase** is **not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **shoulder CPM unit rental** 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.

Expert Reviewer Case Summary:

There was no clinical summary provided in the Utilization Review Determination from Coventry.

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 Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

- 1) **Regarding the request for O tech recovery system (hot/cold compression DVT) 35 day rental home use :**
Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not offer guidelines from which to base 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), Current Version, Continuous Flow Cryotherapy, which is not part of the MTUS.

Rationale for the Decision:

The Official Disability Guidelines (ODG) do recommend hot/cold device up to 7 days status post surgical intervention. The request for a 35 day rental would exceed evidence based guidelines for total duration of care. From the submitted documents for review, there is lack of an operative report demonstrating the employee has undergone specific surgery to warrant the use of this DME device. **The request for O tech recovery system (hot/cold compression DVT) 35 day rental home use is not medically necessary and appropriate.**

2) Regarding the request for half warm 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 offer guidelines from which to base 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), Current Version, Continuous Flow Cryotherapy, which is not part of the MTUS.

Rationale for the Decision:

The request was previously non-certified for unclear rationale. However, as the concurrent request for the O tech recovery system was non-certified, the associated half warm wrap purchase would likewise be not medically necessary. **The request for half warm wrap, purchase is not medically necessary and appropriate.**

3) Regarding the request for universal therapy wrap for purchase :

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

The Claims Administrator did not offer guidelines from which to base 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), Current Version, Continuous Flow Cryotherapy, which is not part of the MTUS.

Rationale for the Decision:

The request was previously non-certified for unclear rationale. However, as the concurrent request for the O tech recovery system 35 day rental was non-certified, the associated request for a universal therapy wrap would likewise be not medically necessary. **The request for universal wrap for purchase is not medically necessary and appropriate.**

4) Regarding the request for shoulder CPM unit rental :

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

The Claims Administrator did not offer guidelines from which to base 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), Current Version, Continuous Passive Motion (CPM), which is not part of the MTUS.

Rationale for the Decision:

The Official Disability Guidelines state that continuous passive motion (CPM) devices are not recommended for rotator cuff problems but are an option for adhesive capsulitis. The documentation provided does not include an operative report to specify the specific surgery the employee underwent. The notes do indicate the employee is status post left shoulder rotator cuff repair. Therefore, based on the available documentation, the request for shoulder CPM unit rental is not medically supported. **The request for shoulder CPM unit rental 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, 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.