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**Notice of Independent Medical Review Determination**

Dated: 10/14/2013

[REDACTED]

[REDACTED]

[REDACTED]

Employee:

Claim Number:

Date of UR Decision:

Date of Injury:

IMR Application Received:

MAXIMUS Case Number:

[REDACTED]  
7/11/2013

11/4/2011

7/26/2013

CM13-0003697

- 1) MAXIMUS Federal Services, Inc. has determined the request for a Coolcare cold therapy unit **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for continuous passive motion (CPM) for an initial period of 45 days **is not medically necessary and appropriate.**

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 7/26/2013 disputing the Utilization Review Denial dated 7/11/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/1/2013. 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 Coolcare cold therapy unit **is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for continuous passive motion (CPM) for an initial period of 45 days **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 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 11, 2013:

“Clinical summary: According to Office Visit dated 06/10/13 by Dr. [REDACTED], the patient complained of left shoulder pain rated 8/10. On examination: there was severe tenderness on supraspinatus, moderate on greater tuberosity, mild on biceps tendon, and moderate on acromioclavicular joint; there was positive subacromial crepitus. Range of motion: forward flexion 100 degrees, extension 40 degrees, abduction 100 degrees, adduction 40 degrees, external rotation 80 degrees, and internal rotation 45 degrees. Muscle strength and Tone: forward flexion 4/5, abduction 4/5, external rotation 4/5, internal rotation 4/5, noted positive painful shoulder movement; noted positive distal sensation normal to light touch. There was tenderness over the cervical spinous process and negative head compression test. Provocative test: positive for acromioclavicular joint compression test, and impingement test. Past medical history was not documented in the clinical records submitted. There was a request authorization for left shoulder arthroscopic evaluation. arthroscopic rotator cuff repair, decompression and distal clavicle resection surgery. The patient was diagnosed with rotator cuff syndrome of shoulder and allied disorders; and adhesive capsulitis of shoulder. This is a request for CPM with initial period of 45 days, Post-operative Surgi-stim Unit for purchase, Coolcare Cold Therapy Unit #1.”

### **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 7/26/2013)
- Utilization Review Determination from [REDACTED] (dated 7/11/2013)
- Medical Treatment Utilization Schedule

**NOTE:** Medical Records were not submitted timely by the claims administrator, provider or employee.

#### **1) Regarding the request for a Coolcare 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 American College of Environmental and Occupational Medicine (ACOEM), 2<sup>nd</sup> Edition, (2008), pages 561-563, which are part of the California Medical Treatment Utilization Schedule (MTUS). The Claims Administrator also cited the Official Disability Guidelines (ODG), Shoulder Complaints Chapter, Continuous-Flow Cryotherapy section, which is a medical treatment guideline that is not part of the MTUS. The provider did not dispute the guidelines used by the Claims Administrator. The Expert Reviewer determined the MTUS do not address the issue in dispute. The Expert Reviewer relied on the ODG section used by the Claims Administrator.

##### Rationale for the Decision:

The employee was injured on 11/4/2011 and has experienced left shoulder pain. Diagnoses include rotator cuff syndrome and allied disorders, and adhesive capsulitis of the shoulder. A request was submitted for a Coolcare cold therapy unit.

The ODG supports use of cold therapy units for post-operative rotator cuff repair treatment. An ultrasound dated 4/24/2013 showed an intact right rotator cuff repair with adhesive capsulitis and enlarged left rotator cuff tear involving both supraspinatus and infraspinatus tendons with retraction. The provider recommended rotator cuff repair surgery. The ODG supports use of the requested treatment for the employee's medical condition for post-surgical care. The request for a Coolcare cold therapy unit **is medically necessary and appropriate.**

#### **2) Regarding the request for continuous passive motion (CPM) for an initial period of 45 days:**

##### 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 – Continuous Passive Motion (CPM) 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 California MTUS do not address the issue in 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 was injured on 11/4/2011 and has experienced left shoulder pain. Diagnoses include rotator cuff syndrome and allied disorders, and adhesive capsulitis of the shoulder. A request was submitted for continuous passive motion (CPM) for an initial period of 45 days.

The ODG does not recommend CPM for shoulder rotator cuff problems. The guidelines do recommend CPM use for adhesive capsulitis, but only for 4 weeks. Therefore, the requested CPM with initial period of 45 days exceeds the ODG recommendations. The request for continuous passive motion (CPM) for an initial period of 45 days **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

/sab

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.