

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review

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Notice of Independent Medical Review Determination

Dated: 12/5/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/19/2013
Date of Injury:	9/1/2012
IMR Application Received:	7/26/2013
MAXIMUS Case Number:	CM13-0003907

- 1) MAXIMUS Federal Services, Inc. has determined the request for **pneumatic cold compression unit for right wrist DOS 04/08/2013 to 04/19/2013 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 7/19/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. 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 **pneumatic cold compression unit for right wrist DOS 04/08/2013 to 04/19/2013** 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 Occupational 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 applicant is a represented [REDACTED] Deputy Sheriff who has filed a claim for wrist and knee pain reportedly associated with industrial injury of September 1, 2012.

Thus far, the applicant has been treated with the following: Analgesic medications; attorney representation; apparent diagnosis with an avulsion of the triangular fibrocartilage; right wrist arthroscopy and triangular fibrocartilage repair surgery on April 8, 2013; and extensive periods of time off of work, on total temporary disability.

In a prior utilization review report of July 19, 2013, the claims administrator retrospectively and partially certified a 7-day rental of cold compression device. The applicant's attorney subsequently appealed on July 26, 2013.

Specifically reviewed is an operative report of April 8, 2013, in which the applicant undergoes a right wrist arthroscopically assisted triangular fibrocartilage reattachment.

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 pneumatic cold compression unit for right wrist
DOS 04/08/2013 to 04/19/2013:**

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 Official Disability Guidelines (ODG), 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 Guidelines, Shoulder Chapter, Continuous-flow cryotherapy.

Rationale for the Decision:

The Official Disability Guidelines endorse postoperative cryotherapy for a period of 7 days postoperatively. In this case, however, the request, as written, is for 12 days of continuous flow cryotherapy, and the attending provider did not cite any complications, extenuating factors, or comorbidities which would have required continuous flow cryotherapy in excess of the ODG-endorsed course. **The request for pneumatic cold compression unit for right wrist between the dates of April 8, 2013 through April 19, 2013 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

/hs

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.