

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

(855) 865-8873 Fax: (916) 605-4270



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**Notice of Independent Medical Review Determination**

Dated: 12/11/2013



Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/16/2013
Date of Injury:	5/24/2012
IMR Application Received:	8/2/2013
MAXIMUS Case Number:	CM13-0006364

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

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/2/2013 disputing the Utilization Review Denial dated 7/16/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/26/2013. 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 **cold therapy unit purchase for right shoulder is medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **immobilizer purchase for the right shoulder 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 DOI is 5/24/2012. The patient is a 35 year old female who fell from stairs. An MRI on 7/6/12 showing high grade partial thickness tearing of the distal supraspinatus and infraspinatus tendons. Mild AC joint osteoarthritis with down sloping acromion. Ortho consult dated 6/14/13 showed ROM of 180/90/80 with AC joint tenderness and positive impingement sign. No RC weakness but pain with RC testing. Diagnosis was right RC impingement and AC joint arthrosis pending surgery request. There is no report regarding the specifics of the request for cold therapy or immobilizer.

### **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 cold therapy unit purchase for right shoulder:**

#### 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 Shoulder Complaints, ACOEM Occupational Medicine Practice Guidelines, 2<sup>nd</sup> Ed (2008 Revision), pg 561-563, which is not a 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 (ODG)-Shoulder Chapter.

Rationale for the Decision:

CA MTUS refers to ACOEM for shoulder complaints. ACOEM only refers to the need of surgery regarding the shoulder and does not address immediate post surgical needs. MTUS post surgical guidelines do not address cold therapy, other than the postsurgical treatment should be requested by the surgeon and be used to increase function. Therefore other guidelines are appropriate. ODG recommends continuous flow cryotherapy as an option after surgery. They have been proven to decrease pain, inflammation, swelling, and the narcotic usage. **The request for Cold Therapy Unit Purchase for the Right shoulder is medically necessary and appropriate.**

**2) Regarding the request for immobilizer purchase for the right shoulder:**

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 CA MTUS Shoulder Complaints, ACEOM Practice Guidelines, 2<sup>nd</sup> Edition (2008 Revision), pg.561-563, which is not a part of the MTUS.

The Expert Reviewer based his/her decision on the 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)-Shoulder Chapter, which is not a part of the MTUS.

Rationale for the Decision:

CA MTUS refers to ACOEM for shoulder complaints. ACOEM only refers to the need of surgery regarding the shoulder and does not address immediate post surgical needs. MTUS post surgical guidelines do not address cold therapy, other than the postsurgical treatment should be requested by the surgeon and be used to increase function. Therefore other guidelines are appropriate. ODG refers to postoperative slings: Recommended as an option following open repair of large and massive rotator cuff tears. The sling/abduction pillow keeps the arm in a position that takes tension off the repaired tendon. Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs. (Ticker, 2008). After a review of the medical records provided, " This employee is not undergoing open surgery for the shoulder but is undergoing arthroscopic repair". Therefore ODG does not support the sling. Also, there is no documentation of the exact type of immobilizer. Without this information, there can be no determination of necessity. Therefore as guidelines do not support the immobilizer. **The request for an Immobilizer Purchase for the right shoulder 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, 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.