

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

P.O. Box 138009

Sacramento, CA 95813-8009

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



---

**Independent Medical Review Final Determination Letter**

[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/23/2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/29/2013  
Date of Injury: 9/3/2010  
IMR Application Received: 8/6/2013  
MAXIMUS Case Number: CM13-0007848

DEAR [REDACTED]

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations, [REDACTED]

## HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation has a subspecialty in Pain Medicine and is licensed to practice in Oklahoma and Texas. 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 physician 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 disputed items/services.

### DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

### CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 44-year-old male who reported an injury on 09/03/2010. The patient was noted to have surgery for impingement on 07/24/2013. The treatment requested was noted to be a cold therapy unit, a pneumatic intermittent compression device and an abduction pillow.

### IMR DECISION(S) AND RATIONALE(S)

The Final Determination was based on decisions for the disputed items/services set forth below:

#### **1. 1 Cold Therapy unit is not medically necessary and appropriate.**

The Claims Administrator based its decision on the CA MTUS American College of Occupational and Environmental Medicine (ACEOM), and Chronic Pain Medical Treatment which is part of the MTUS, in addition to Official Disability Guidelines (ODG), Shoulder (Acute and Chronic), which is not part of the MTUS.

The Physician 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 Physician Reviewer based his/her decision Official Disability Guidelines (ODG), Shoulder Chapter, Online Version, Continuous Flow Cryotherapy which is not part of the MTUS.

The Physician Reviewer's decision rationale:

The California MTUS do not address continuous flow cryotherapy.. The Official Disability Guidelines (ODG), recommend continuous flow cryotherapy for up to 7 days postoperatively. The clinical documentation submitted for review indicated that the employee had surgery for

impingement on 07/24/2013. However, the request was made for the purchase of a Polar Care unit, and the clinical documentation submitted for review fails to provide the necessity for the purchase of the unit. Clinical documentation submitted for review failed to provide exceptional factors to warrant nonadherence to guideline recommendations

## **2. 1 Pneumatic Intermittent Compression is not medically necessary and appropriate.**

The Claims Administrator based its decision on the CA MTUS American College of Occupational and Environmental Medicine (ACEOM), and Chronic Pain Medical Treatment which is part of the MTUS. In addition to Official Disability Guidelines (ODG), Shoulder (Acute and Chronic), which is not part of the MTUS.

The Physician 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 Physician Reviewer based his/her decision on The Official Disability Guidelines (ODG), Shoulder Chapter, Compression Devices, Knee & Leg Chapter.

The Physician Reviewer's decision rationale:

The California MTUS/ACOEM Guidelines do not address compression garments. The Official Disability Guidelines (ODG), recommend compression garments in the form of stockings that are effective in the management of prevention of edema and deep vein thrombosis. The clinical documentation submitted for review indicated that the employee had shoulder surgery on 07/24/2013. Clinical documentation failed to provide rationale for the employee needing a pneumatic intermittent compression device instead of the compression stockings that are recommended. Given the above and a lack of exceptional factors to warrant nonadherence to guideline recommendations.

## **3. 1 Abduction Pillow is not medically necessary and appropriate.**

The Claims Administrator based its decision on the CA MTUS American College of Occupational and Environmental Medicine (ACEOM), and Chronic Pain Medical Treatment which is part of the MTUS. In addition to Official Disability Guidelines (ODG), Shoulder (Acute and Chronic), which is not part of the MTUS.

The Physician 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 Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG), Shoulder Chapter, Post-operative Abduction Pillow Sling, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

The California MTUS/ACOEM Guidelines do not address a postoperative abduction pillow sling. The Official Disability Guidelines (ODG), recommend a postoperative pillow sling as an option following an open repair of a large and massive rotator cuff tear. The clinical documentation submitted for review indicated that the employee had a surgical procedure for impingement. The clinical documentation failed to provide exceptional factors to warrant nonadherence to guideline recommendations.

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.

[REDACTED]

CM13-0007848