
Independent Medical Review Final Determination Letter

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Dated: 12/31/2013

IMR Case Number:	CM13-0024258	Date of Injury:	10/24/2007
Claims Number:	[REDACTED]	UR Denial Date:	08/23/2013
Priority:	STANDARD	Application Received:	09/13/2013
Employee Name:	[REDACTED]		
Provider Name:	[REDACTED]		
Treatment(s) in Dispute Listed on IMR Application:			
A4556, A4630, A9901, E0218, E0730, E1399			

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 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 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:

This is a 60-year-old gentleman who was injured in a work-related accident on 10/24/07. He sustained an injury to the right shoulder. Recent clinical records for review include a 10/2/13 progress report of Dr. [REDACTED] indicating subjective complaints to the elbow status post right elbow open lateral epicondylar debridement and repair of extensor mass from 4/26/13. It stated that he continued to make slow but steady progress with continued weakness and tingling to the right hand. Objective findings revealed a well-healed incision and full range of motion with stiffness at end points. The claimant's current diagnosis is that of bilateral shoulder rotator cuff impingement status post right elbow open lateral epicondylar debridement with extensor mass repair. The recommendations at that time were for continuation of physical therapy as well as a self-directed stretching and strengthening program, icing, anti-inflammatory agents, and avoidance of excessive activities and repetitive use of the elbow. There are also current requests for continued use of a DonJoy IceMan Clear Cube, a shoulder cold pad, a patient set-up and educational session, as well as use of a TENS unit with battery and electrodes.

IMR DECISION(S) AND RATIONALE(S)

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

1. DonJoy IceMan Clear Cube is not medically necessary and appropriate.

The Claims Administrator based its decision: Not clear from the UR determination

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 Expert Reviewer based his/her decision on Official Disability Guidelines (ODG)-- Official Disability Guidelines Treatment in Worker's Comp , 18th Edition, 2013 Updates: Shoulder Procedure – Continuour-flow crytherapy, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

Based on Official Disability Guidelines criteria, as California ACOEM Guidelines and California MTUS Chronic Pain Guidelines are silent, continued use of a DonJoy Iceman Clear Cube would not be indicated. While the clinical guidelines support the role of cryotherapy units for seven days following surgical processes, this claimant is now several months from the procedure for which the use of this acute modality would not be indicated. The clinical records would not support its use at present.

2. Shoulder cold pad therapy unit is not medically necessary and appropriate.

The Claims Administrator based its decision on the: Not clear from the UR determination

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 Expert Reviewer based his/her decision on Official Disability Guidelines (ODG)-- Official Disability Guidelines Treatment in Worker's Comp , 18th Edition, 2013 Updates: Shoulder Procedure – Continuour-flow crytherapy, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

Based on Official Disability Guidelines criteria, as California ACOEM Guidelines and California MTUS Chronic Pain Guidelines are silent, the use of a cryo device to the shoulder would not be indicated. Cryotherapy devices are only indicated following surgical intervention to the shoulder for seven day use. The records do not indicate a surgical process to the shoulder has occurred thus there would not be a need for the requested shoulder pad for the cryotherapy unit.

3. Patient set-up/education/filling fee is not medically necessary and appropriate.

The Claims Administrator based its decision on the: Not clear from the UR determination

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 Expert Reviewer based his/her decision on Official Disability Guidelines (ODG)-- Official Disability Guidelines Treatment in Worker's Comp , 18th Edition, 2013 Updates: Shoulder Procedure – Continuour-flow crytherapy, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

Based on Official Disability Guidelines criteria, the role of a patient set-up education setting would not be indicated as the devices in question are not supported for use at present.

4. TENS 2 lead rental for 5 months is not medically necessary and appropriate.

The Claims Administrator based its decision on the: Not clear from the UR determination

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Transcutaneous electrical nerve stimulation (TENS), pages 114-116, which is part of the MTUS.

The Physician Reviewer's decision rationale:

Based on California MTUS Chronic Pain Guidelines, a TENS unit is not recommended as a primary treatment modality. It is only indicated for neuropathic pain, Chronic Regional Pain Syndrome, and in the chronic pain situation where failed conservative management has occurred. The claimant's records indicate a surgical process to the elbow which in and of itself is not a diagnosis that would not support the post-operative use of a TENS device. The role of this modality would not be indicated.

5. Batteries 9 volt is not medically necessary and appropriate.

The Claims Administrator based its decision on the: Not clear from the UR determination

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Transcutaneous electrical nerve stimulation (TENS), pages 114-116, which is part of the MTUS.

The Physician Reviewer's decision rationale:

Based on California MTUS Chronic Pain Guidelines, the TENS device is not indicated thus the need of batteries for the above device would not be indicated as well.

6. Electrodes for TENS unit is not medically necessary and appropriate.

The Claims Administrator based its decision on the: Not clear from the UR determination

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Transcutaneous electrical nerve stimulation (TENS), pages 114-116, which is part of the MTUS.

The Physician Reviewer's decision rationale:

Based on California MTUS Chronic Pain Guidelines, a TENS unit has not been supported thus the need of electrodes for the device would not be indicated in this setting.

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.

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