

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Independent Medical Review Final Determination Letter**

[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/23/2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 8/13/2013  
Date of Injury: 7/15/2013  
IMR Application Received: 8/19/2013  
MAXIMUS Case Number: CM13-0013860

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, New Jersey and Pennsylvania. 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 claimant is a 51 year old male injured on July 15, 2013 secondary to performing repetitive tasks. The claimant's initial complaint was left shoulder pain. The clinical progress report August 23, 2013 indicated continued complaints of shoulder pain, weakness and an inability to perform normal activities. Subjectively there was diminished supraspinatus strength at 4/5, moderate positive impingement testing and moderate pain along the bicipital groove. It was noted at that time the claimant had recently undergone a shoulder arthroscopy with rotator cuff repair. There are postoperative requests for twelve weeks of postoperative home care support as well as a request for a Thermozone continuous thermal therapy device for use of the left shoulder with pad attachments. Further postoperative records are unavailable for review. The specific date of surgical intervention is not noted from the records.

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

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

**1. The request for twelve (12) weeks of home health care is not medically necessary and appropriate.**

The Claims Administrator based its decision on the California MTUS Chronic Pain Guidelines, 2009, Page 51 and the American College of Occupational and Environmental Medicine (ACOEM), Occupational Medicine Practice Guidelines, 2<sup>nd</sup> Edition, Chapter 9, web version, which is part of the MTUS and the Official Disability Guidelines, web version, Shoulder, which is not part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Home Health Services, Page 51, which is part of the MTUS.

The Physician Reviewer's decision rationale:

Based on the CA MTUS Chronic Pain Guidelines, home health services for twelve weeks following a shoulder arthroscopy and rotator cuff repair would not be supported. The medical records reviewed do not indicate this employee as being homebound even on an intermittent basis with the procedure in question. There would be no clinical indication as to why the employee would not be able to care for himself at the twelve week mark following operative procedure, even well before then, given the nature of the surgery in question. **The request for twelve (12) weeks of home health care is not medically necessary and appropriate.**

**2. The request for Thermazone continuous thermal therapy device with left shoulder pad attachment is not medically necessary and appropriate.**

The Claims Administrator based its decision on the The Claims Administrator based its decision on the California MTUS Chronic Pain Guidelines, 2009, Page 51 and the American College of Occupational and Environmental Medicine (ACOEM), Occupational Medicine Practice Guidelines, 2<sup>nd</sup> Edition, Chapter 9, web version, which is part of the MTUS and the Official Disability Guidelines, web version, Shoulder, 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 (ODG), 18<sup>th</sup> Edition, 2013 Updates: Shoulder Procedure, Thermotherapy, which is not part of the MTUS.

The Physician Reviewer's decision rationale:

The CA ACOEM and MTUS Guidelines are silent. When looking at the Official Disability Guidelines criteria Thermotherapy would not be indicated. Thermotherapy is under study for use in the shoulder. It is lacking long term evidence regarding its efficacy. It is not the standard of care in regards to rotator cuff repair procedures or arthroscopic postoperative setting. The need for this modality would not be indicated. **The request for Thermazone continuous thermal therapy device with left shoulder pad attachment is not medically necessary and appropriate.**

/jb

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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[REDACTED]  
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