

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
P.O. Box 138009
Sacramento, CA 95813-8009
(855) 865-8873 Fax: (916) 605-4270



Notice of Independent Medical Review Determination

Dated: 11/5/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/26/2013
Date of Injury:	4/21/2011
IMR Application Received:	8/1/2013
MAXIMUS Case Number:	CM13-0005688

- 1) MAXIMUS Federal Services, Inc. has determined the request for 90 days rental of Surgi-Stim unit **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 45 days rental of continuous passive motion device **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for 90 days rental of Coolcare cold therapy unit **is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/1/2013 disputing the Utilization Review Denial dated 7/26/2013. A Notice of Assignment and Request for Information was provided to the above parties on 8/21/2013. 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 90 days rental of Surgi-Stim unit **is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for 45 days rental of continuous passive motion device **is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for 90 days rental of Coolcare cold therapy unit **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 Physical Medicine and Rehabilitation 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 patient is a 49-year-old female who reported an injury to her shoulder due to cumulative trauma from performing her job duties. The date of injury was reported to be 04/21/2011. The clinical note dated 06/10/2013 reported the patient had developed right shoulder pain as a result of lifting, pushing, pulling at her job site. She is noted to have received medication, physical therapy, acupuncture and shock wave therapy all without significant benefit. Her pain level was reported to be 8/10. The patient was noted to have decreased range of motion in all planes of the right shoulder and to have severe supraspinatus tenderness to palpation, moderate tenderness over the greater tuberosity, mild tenderness over the biceps tendon, and mild AC joint tenderness. The patient is noted to have subacromial crepitus on physical exam and 4/5 strength of the right shoulder in external rotation, internal rotation and abduction. Shoulder movements were noted to be painful. The patient is noted to have a positive AC joint compression test, positive impingement 1 test, impingement 2 test and impingement 3 test. An ultrasound study reported to have been performed on 12/18/2012 reported tendinosis of the distal supraspinatus subscapularis tendons with no findings evidence of rotator cuff tear which were consistent with supraspinatus outlet impingement and severe degenerative changes of the acromioclavicular joint. The patient was planned for a right shoulder arthroscopic evaluation, subacromial decompression and distal clavicle excision.

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 90 days rental of Surgi-Stim unit :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert Reviewer found the Chronic Pain Medical Treatment Guidelines, Transcutaneous electrotherapy, page 121, which is part of the MTUS.

Rationale for the Decision:

The MTUS Chronic Pain Guidelines do not recommend the use of neuromuscular electrical stimulation stating that neuromuscular electrical stimulation is primarily used as part of a rehabilitation program following a stroke and there is no evidence to support its use in chronic pain noting that NMES devices are used to prevent or retard disuse atrophy, relax muscle spasm, increase blood circulation, maintain or increase range-of-motion, and re-educate muscles. The records reviewed do not provide an indication that the employee has a loss of range of motion or muscle atrophy and as such the request for a 90 day rental of a Surgi-Stim unit is not indicated. **The request for 90 days rental of a Surgi-Stim unit is not medically necessary and appropriate.**

2) Regarding the request for 45 days rental of continuous passive motion device :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision :

The Claims Administrator did not cite any evidence based criteria for its decision.

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), Online Version, Shoulder (acute and chronic) Chapter, continuous passive motion, which is not part of the MTUS.

Rationale for the Decision:

The Official Disability Guidelines indicate that continuous passive motion is recommended for shoulder rotator cuff problems and indicate that it is recommended for an option for adhesive capsulitis up to 4 weeks. The medical records indicate the employee is being treated for rotator cuff tendinosis due to impingement syndrome but the records do not indicate the employee has

adhesive capsulitis. **The request for 45 days rental of a continuous passive motion device is not medically necessary and appropriate.**

3) Regarding the request for 90 days rental of Coolcare cold therapy unit :

Section of the Medical Treatment Utilization Schedule Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite specific guidelines from which to base its decision.

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), Online Version, Shoulder (acute and chronic) Chapter, Continuous Flow Cryotherapy, which is not part of the MTUS

Rationale for the Decision:

The Official Disability Guidelines recommend the use of continuous flow cryotherapy as an option after surgery for up to 7 days including home use. As such, the requested 90 day rental of a Coolcare cold therapy unit postoperative does not meet guideline recommendations. **The request for 90 days rental of a Coolcare cold therapy unit 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

/bh

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.