

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Medical Review

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**Notice of Independent Medical Review Determination**

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Dated: 11/12/2013

[REDACTED]

[REDACTED]

Employee:	[REDACTED]
Claim Number:	[REDACTED]
Date of UR Decision:	7/25/2013
Date of Injury:	2/24/2010
IMR Application Received:	8/5/2013
MAXIMUS Case Number:	CM13-0007115

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

## INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/5/2013 disputing the Utilization Review Denial dated 7/25/2013. A Notice of Assignment and Request for Information was provided to the above parties on 9/16/2013. 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 **1 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 Preventive Medicine and 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:**

All medical, insurance, and administrative records provided were reviewed.

The applicant is a represented [REDACTED] employee who has filed a claim for chronic low back, shoulder, neck, and wrist pain, reportedly associated with an industrial injury of February 24, 2010.

Thus far, applicant has been treated with the following: Analgesic medications; adjuvant medications; interferential therapy device; and extensive periods of time off from work.

In a utilization review report of July 25, 2013, a continuous cooling device is non-certified.

A January 9, 2013, note suggests that the applicant remains off of work, on total temporary disability. Several other notes interspersed throughout 2013, including April 23, 2013, February 12, 2013, April 23, 2013, and June 6, 2013, all suggested that the applicant remains off of work, on total temporary disability. It is stated that the applicant later underwent a flexor tenosynovectomy and carpal tunnel release surgery on March 16, 2013.

### **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 1 cold therapy unit:**

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 Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 11) pg. 265, which is part of the MTUS, and the Official Disability Guidelines, Carpal Tunnel Syndrome (Acute & Chronic), which is not part of the MTUS.

The Expert Reviewer based his/her decision on the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 11), Table 11-4, which is part of the MTUS, and ACOEM, 3<sup>rd</sup> Edition, Chronic pain, General Principals of Treatment, Allied Health Professionals, Allied Health Therapies, which is not part of the MTUS.

Rationale for the Decision:

As noted in the MTUS-adopted ACOEM Guidelines in Chapter 11, at-home applications of cold are indicated in the first few days following an acute complaint; thereafter, heat packs can be employed. ACOEM further notes that patients' at-home applications of heat and cold are as effective as those performed by a therapist, or by implication, those delivered through high-tech means. The submitted and reviewed records provided no compelling rationale for usage or purchase of a continuous cooling device or high-tech devices to deliver heat or cold. **The request for 1 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, 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.