

Case Number:	CM13-0036181		
Date Assigned:	03/19/2014	Date of Injury:	08/02/2012
Decision Date:	05/08/2014	UR Denial Date:	09/24/2013
Priority:	Standard	Application Received:	10/18/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in 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 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 disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

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

The injured worker is a 55 year-old male who reported an injury on 08/02/2012 and the mechanism of injury was from a fall. The injured worker was diagnosed with right shoulder pain and low back. He has been treated with physical therapy and chiropractic care as well as aspirin, Tylenol, hydrocodone/acetaminophen 10/325mg, Soma 350mg and Motrin. MRI of the right shoulder reportedly revealed degenerative changes in the biceps tendon labral complex with no obvious tears, mild degenerative changes in the supraspinatus and infraspinatus tendons, AC joint bony hypertrophy, moderately severe compression of the supraspinatus muscle and tendon by hypertrophied AC joint and moderate lateral down-sloping of the type II acromion. According to the most recent office note submitted for review dated 01/22/2013, the patient complained of right shoulder pain with numbness and tingling in the back of his shoulder. Examination revealed 5/5 strength in the bilateral upper extremities with positive Neer's test on the right. A request was submitted for an immobilizer sling with abduction pillow, cold therapy unit [REDACTED] 7 day rental, cold therapy unit [REDACTED] 14 day rental. The information for review did not include recent records to indicate that a shoulder surgery had been done and why the immobilizer sling with abduction pillow and the cold therapy unit [REDACTED] 14 day rental.

IMR ISSUES, DECISIONS AND RATIONALES

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

IMMOBILIZER SLING WITH ABDUCTION PILLOW: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 561-563.
Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Postoperative Abduction Pillow Sling

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS.
Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)
SHOULDER, POSTOPERATIVE ABDUCTION PILLOW SLING

Decision rationale: The Official Disability Guidelines (ODG), indicate that for a postoperative abduction pillow sling they are recommended as an option following open repair of large and massive rotator cuff tears. The sling/abduction pillow keeps the arm in a position that takes tension off the repaired tendon. Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs. The information for review did not include recent records to indicate that a shoulder surgery had been done or planned and why the immobilizer sling with abduction pillow would be required. Therefore, the immobilizer sling with abduction pillow is not medically necessary.

COLD THERAPY UNIT [REDACTED] 14 DAY RENTAL: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 561-563.
Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Continuous-Flow Cryotherapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS.
Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)
SHOULDER, CONTINUOUS-FLOW CRYOTHERAPY

Decision rationale: The Official Disability Guidelines (ODG), Continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. The information for review did not include recent records to indicate that a shoulder surgery had been done or planned for and why The information for review did not include recent records to indicate that a shoulder surgery had been done and why the cold therapy unit [REDACTED] 14 day rental would be required. The guidelines only support for 7 days postoperative. Therefore, the request for the cold therapy unit [REDACTED] [REDACTED] 14 day rental is not medically necessary.