

<b>Case Number:</b>	CM14-0013387		
<b>Date Assigned:</b>	02/26/2014	<b>Date of Injury:</b>	08/10/1999
<b>Decision Date:</b>	07/14/2014	<b>UR Denial Date:</b>	01/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2014

### 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 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 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:

Patient is a 56-year-old male who has submitted a claim for s/p left shoulder arthroscopic exploration cuff repair, subacromial decompression; s/p right shoulder open exploration, with lysis of adhesions and impingement release associated with an industrial injury date of August 10, 1999. Medical records from 2013 were reviewed which revealed continuous complaint of shoulder pain. Physical examination of left shoulder showed no significant swelling, erythema, warmth, discharge or dehiscence on the incision site. Passive forward flexion was 170 degrees. Distal range of motion and strength were intact. Impingement sign was positive. Treatment to date has included, left shoulder arthroscopic exploration and repair done on 1/23/14, subacromial decompression, right shoulder open exploration with lysis of adhesions and impingement release. Utilization review from January 21, 2014 denied the requests for shoulder immobilizer with abduction pillow and cold therapy unit purchase, sterile wrap and sterile pad. Shoulder immobilizer was denied because guidelines recommend its use for open repair of massive rotator cuff tear. Regarding cold therapy unit, sterile wrap and sterile pad purchases, it was only recommended for immediate postoperative period and for rental use only.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**SHOULDER IMMOBILIZER WITH ABDUCTION PILLOW:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Postoperative Abduction Pillow Sling.

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Official Disability Guidelines, Shoulder Chapter, was used instead. The ODG recommend immobilizer/abduction pillow as an option following open repair of large and massive rotator cuff tears. In this case, patient did not have massive rotator cuff tear. He only underwent left shoulder arthroscopic exploration cuff repair and not open repair. There is no compelling rationale that would warrant the need for shoulder immobilizer with abduction pillow. Guidelines are not met. Therefore, the request for SHOULDER IMMOBILIZER WITH ABDUCTION PILLOW is not medically necessary.

**COLD THERAPY UNIT PURCHASE, STERILE WRAP AND STERILE PAD PURCHASES:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Continuous Flow Cryotherapy Section.

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, Official Disability Guidelines, Shoulder Chapter, was used instead. ODG indicates continuous flow cryotherapy as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days rental, including home use. In this case, patient underwent left shoulder arthroscopic exploration and repair dated 1/21/14. However, the request is for purchase of cold unit, sterile pads and wraps. Guidelines only support 7-day rental of unit and not of purchase. In addition, he had the procedure on January 23, 2014. However, guidelines recommend the use of cold unit in immediate postoperative state. Therefore, the request for COLD THERAPY UNIT PURCHASE, STERILE WRAP AND STERILE PAD PURCHASES is not medically necessary.