

<b>Case Number:</b>	CM14-0112499		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	06/28/2013
<b>Decision Date:</b>	11/12/2014	<b>UR Denial Date:</b>	07/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/18/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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:

The patient is a 39 year old with an injury date on 6/28/13. Patient complains of mild aching pain felt anteriorly and anterosuperiorly at the left shoulder when she is at rest per 6/25/14 report. The pain is well localized without particular radiation, and no soft tissue swelling is described per 6/25/14 report. The patient is planning to undergo a left shoulder arthroscopic rotator cuff repair, subacromial decompression and distal clavicle resection per 6/25/14 report. Based on the 6/25/14 progress report provided, the diagnoses are: 1. partial thickness bursal side supraspinatus tear, left shoulder 2. subacromial impingement, left shoulder 3. symptomatic acromioclavicular arthritis/inflammation, left shoulder 4. partial thickness tearing of the infraspinatus and subscapularis, left shoulder 5. superior labral fraying, left shoulder 6. multiple other body part injuries 7. obesity (BMI 51.5) Exam on 6/25/14 showed "left shoulder range of motion is limited with extension at 35 degrees. No crepitus with range of motion, no effusion." The treater is requesting abduction pillow/immobilizer and CTU - E0218. The utilization review determination being challenged is dated 7/8/14 and denies request for a pillow but modifies request to approve the sling.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Abduction pillow/immobilizer:** Overturned

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck chapter online for Pillow and Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin: Pillows and Cushions. Policy Number 00456

**Decision rationale:** This patient presents with left shoulder pain. The treater has asked for abduction pillow/immobilizer. ODG guidelines recommend a pillow as a neck support pillow while sleeping in conjunction with daily exercise. Aetna Clinical Policy Bulletin allows cushions if it is an integral part of or a medically necessary accessory to, covered DME. In this case, the patient is being scheduled for a left shoulder arthroscopic rotator cuff repair of unspecified date. The requested abduction pillow/immobilizer is a part of a post-surgical shoulder sling, and such a request appears to be reasonable.

**Cold therapy unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability 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, section on Continuous-flow cryotherapy

**Decision rationale:** This patient presents with left shoulder pain. The treater has asked for CTU - E0218. Regarding cryotherapy, ODG allows for short-term post-operative use for 7 days. ODG states that no research shows any additional added benefit for more complicated cryotherapy units over conventional ice bags or packs. In this case, the patient is planning for a left shoulder arthroscopic rotator cuff repair. However, ODG does not recommend complicated cold therapy units as they do not show added benefit over conventional ice packs. The requested CTU is not indicated for this patient at this time.