

<b>Case Number:</b>	CM14-0157769		
<b>Date Assigned:</b>	10/01/2014	<b>Date of Injury:</b>	08/20/2013
<b>Decision Date:</b>	10/28/2014	<b>UR Denial Date:</b>	09/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2014

### 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 Family Medicine and is licensed to practice in Arizona. 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 46 year old female with a date of injury on 8/20/2013. Subjective complaints are of ongoing bilateral shoulder pain. Physical exam shows tenderness to palpation at the right coracoacromial arch, and diffuse left shoulder tenderness. The right shoulder had positive impingement signs without instability. Right shoulder MRI from 5/6/14 showed supraspinatus tendinosis and possible SLAP lesion, left shoulder MRI showed mild supraspinatus tendonitis. Medications include Tramadol and Naprosyn. Prior treatment has also included physical therapy and a steroid injection. The patient is diagnosed with right rotator cuff tendinopathy, and there is a request for diagnostic right shoulder arthroscopy. There is no indication in the records if this surgical request has been certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**SHOULDER ABDUCTION SLING (FOR PURCHASE):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212.

**Decision rationale:** The ACOEM does not recommend prolonged use of an immobilization sling for the shoulder. A sling may be considered for several days for severe shoulder pain or after initial shoulder dislocation or reduction. This patient has rotator cuff tendinopathy and does not appear to have a current severe exacerbation to warrant use of a sling. Furthermore, while post-operative medical equipment may be utilized after surgery, the records do not identify certification for surgery. Therefore, the medical necessity for an abduction sling is not established at this time.

**CRYOTHERAPY (4 WEEKS RENTAL):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**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 ODG recommends cryotherapy after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. For this patient, records do not indicate that surgery has been certified. Furthermore, the request for 4 weeks of cryotherapy exceeds guideline recommendations. Therefore, the medical necessity for continuous flow cryotherapy is not established at this time.