

<b>Case Number:</b>	CM15-0104852		
<b>Date Assigned:</b>	06/09/2015	<b>Date of Injury:</b>	07/24/2013
<b>Decision Date:</b>	07/10/2015	<b>UR Denial Date:</b>	05/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/01/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 57-year-old male, who sustained an industrial injury on 7/24/13. The UR letter reported he had bilateral shoulder pain and dysfunction, worse of the left. The injured worker was diagnosed as having right shoulder partial thickness rotator cuff tear and left shoulder full thickness rotator cuff tear SLAP. Treatment to date has included left shoulder arthroscopy with intraarticular debridement of partial torn rotator cuff and biceps tenotomy and subacromial decompression, physical therapy, home exercise program, oral pain medications and activity restrictions. Currently, the injured worker complains of left shoulder pain. He is currently not working. Physical exam noted tenderness an anterior acromial margins with positive impingement prior to surgery. A treatment plan or request for authorization was not submitted with documentation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-operative cold compression unit x30 day rental:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (Knee and Leg Chapter- Cryotherapy).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, cryotherapy.

**Decision rationale:** The California MTUS and the ACOEM do not specifically address the requested service. The ACOEM does recommend the at home local application of cold packs the first few days after injury and thereafter the application of heat packs. The Official Disability Guidelines section on cryotherapy states: Recommended as an option after surgery but not for non-surgical treatment. The request is for post-surgical use however, the time limit for request is not defined. Per the ODG, cold therapy is only recommended for 7 days post operatively. The request is in excess of this amount and therefore is not medically necessary.

**Post-operative wrap for purchase:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, shoulder surgery.

**Decision rationale:** The California MTUS and the ACOEM do not specifically address the requested service. The ODG chapter on upper extremity surgery does not recommend compression wrap due to risk of adhesive capsulitis as well as low risk of DVT associated with these surgeries. Therefore, the request is not medically necessary.

**Post-operative abduction arm support for purchase:** Overturned

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, shoulder surgery.

**Decision rationale:** The California MTUS and the ACOEM do not specifically address the requested service. The ODG chapter on upper extremity shoulder surgery does support the requested durable medical equipment for post-surgical use. The patient has been approved for an ultrasling. Therefore, the request is medically necessary as part of the medical necessity post shoulder surgery.