

<b>Case Number:</b>	CM15-0208397		
<b>Date Assigned:</b>	10/27/2015	<b>Date of Injury:</b>	09/24/2012
<b>Decision Date:</b>	12/08/2015	<b>UR Denial Date:</b>	10/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/22/2015

### 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: Arizona, California  
 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 36 year old male, who sustained an industrial injury on 09-24-2012. The injured worker is currently working full duty. Medical records indicated that the injured worker is undergoing treatment for left rotator cuff impingement and acromioclavicular joint arthritis. Treatment and diagnostics to date has included wrist physical therapy, shoulder injection, and medications. Recent medications have included Norco. Subjective data (06-30-2015 and 09-28-2015), included left shoulder pain. Objective findings (09-28-2015) included left shoulder tenderness at the acromioclavicular joint and positive impingement sign and O'Brien's test. The treating physician noted that the injured worker would like to proceed with surgical treatment. The request for authorization dated 10-08-2015 requested preoperative CBC-CMP, postoperative physical therapy, cold therapy unit-immobilizer for purchase, and postoperative Norco. The Utilization Review with a decision date of 10-15-2015 modified the request for immobilizer for the left shoulder, postoperatively to use of a standard Ultrasling during the rehab period.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-operative Immobilizer for the left shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care, Activity Modification, Summary. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder chapter and pg 18` and pg.

**Decision rationale:** According to the guidelines, immobilization may be used briefly but prolonged use is not recommended and can lead to stiffness and adhesive capsulitis. In this case, the sling may be required post-operatively, but length of use was not specified. A cold therapy immobilizer unit is only recommended for up to 7 days after surgery. Purchase for long-term use is not indicated and is not medically necessary.