

<b>Case Number:</b>	CM15-0220022		
<b>Date Assigned:</b>	11/13/2015	<b>Date of Injury:</b>	01/09/2013
<b>Decision Date:</b>	12/31/2015	<b>UR Denial Date:</b>	10/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/09/2015

### 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: Texas, Illinois

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 50 year old male who sustained an industrial injury on 1-9-2013. A review of medical records indicates the injured worker is being treated for status post right shoulder surgery, subacromial decompression and biceps tenodesis. Medical records dated 9-18-2015 noted he has difficulty lifting things above his head, but has improved. Past medical history is unchanged from his last visit. Physical examination noted tenderness to palpation about the right shoulder. Slings were not mentioned in the progress report. Treatment has included 12 sessions of physical therapy. Utilization review form dated 10-9-2015 non-certified stable sling and Kodiak combo shoulder dispensed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective stable sling dispensed 4/23/15: 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, Postoperative abduction pillow sling.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic), Postoperative abduction pillow sling.

**Decision rationale:** The injured worker sustained a work related injury on 1-9-2013. The medical records provided indicate the diagnosis of status post right shoulder surgery, subacromial decompression and biceps tenodesis. Treatment has included Surgery, 12 sessions of physical therapy. The medical records provided for review do not indicate a medical necessity for Retrospective stable sling dispensed 4/23/15. The MTUS is silent on it, but the Official Disability Guidelines states, Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs. A post-op sling is generally recommended for 2-4 weeks after any shoulder surgery. A good protocol is to begin weaning off the sling at two weeks, reducing the number of hours per day it is worn. The medical records indicate the injured worker had right shoulder arthroscopy with subacromial decompression, the right shoulder arthroscopy with extensive debridement of glenohumoral joint, right shoulder manipulation under anesthesia, and right shoulder open biceps tenodesis on 04/23/15. The records indicate the request is for authorization for the supply of the Durable Medical Equipment, stable sling. The requested treatment is not medically necessary since this was an arthroscopic surgery. Also, the request did not specify how the sling would be used.

**Retrospective Kodiak combo shoulder dispensed 4/23/15: 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 procedure, Continuous-flow cryotherapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic), Continuous-flow cryotherapy.

**Decision rationale:** The injured worker sustained a work related injury on 1-9-2013. The medical records provided indicate the diagnosis of status post right shoulder surgery, subacromial decompression and biceps tenodesis. Treatment has included Surgery, 12 sessions of physical therapy. The medical records provided for review do not indicate a medical necessity for Retrospective Kodiak combo shoulder dispensed 4/23/15. The MTUS is silent on it, but the Official Disability Guidelines recommends it as an option after surgery after surgery for 7, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. There was no information in the request stating the request is for up to 7 days use after surgery. Therefore, the requested treatment is not medically necessary.