

<b>Case Number:</b>	CM15-0057840		
<b>Date Assigned:</b>	04/02/2015	<b>Date of Injury:</b>	05/31/2014
<b>Decision Date:</b>	05/06/2015	<b>UR Denial Date:</b>	02/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/26/2015

### 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: California

Certification(s)/Specialty: Orthopedic Surgery

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 41 year old female sustained an industrial injury on 5/31/14. She subsequently reported injury to bilateral shoulder and left wrist. Diagnoses include bilateral shoulder impingement and tendinitis, right shoulder partial tear of the supraspinatus tendon, left shoulder rotator cuff tear and lumbar spine sprain/strain. Diagnostic testing has included MRIs. Treatments to date have included injections, wrist and shoulder surgery and prescription pain medications. The injured worker continues to experience low back and bilateral upper extremity pain. A request for a hot/cold unit and a pro sling with abduction pillow was made by the treating physician. Exam note 11/13/14 demonstrates bilateral shoulder pain. Exam demonstrates 4/5 strength in all planes in bilateral shoulders. Request is made for a left shoulder arthroscopic subacromial decompression and excisional acromioclavicular joint arthroplasty.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hot/Cold unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES GUIDELINES.

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

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. In this case the request is for an unspecified amount of days. Therefore the determination is for non-certification.

**Pro Sling with abduction pillow (is certified only if the shoulder surgery is certified):**  
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, Abduction pillow.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of abduction pillow. Per the ODG criteria, abduction pillow is recommended following open repair of large rotator cuff tears but not for arthroscopic repairs. In this case there is no indication from the exam note of 11/13/14 for need for open rotator cuff repair and therefore determination is for non-certification.