

<b>Case Number:</b>	CM14-0210347		
<b>Date Assigned:</b>	12/23/2014	<b>Date of Injury:</b>	03/01/2009
<b>Decision Date:</b>	02/28/2015	<b>UR Denial Date:</b>	11/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/15/2014

### 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. 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:

71 year old claimant with reported industrial injury of 3/1/09, exam note 01/14/14 indicates the claimant injured the left shoulder in 03/2009 and developed right shoulder pain. The claimant underwent right shoulder arthroscopy with debridement and synovectomy, acromiopiasty, SLAP repair and revision rotator cuff repair on 11/12/12. On 10/31/13, the claimant was seen again due to increased pain since 09/2013 when the claimant lifted a 25-pound computer. The provider recommends medications and MR arthrogram of the right shoulder. MR arthrogram 08/04/14 reveals prior shoulder surgery with suture anchors at the humeral head and a partial acromionectomy. There is a complete thickness tear of the supraspinatus tendon with approximately 28.4mm of medial retraction. There is a complete full-thickness tear of the infraspinatus tendon with approximately 44.2 mm of medial retraction. There is a high grade partial versus full thickness subscapularis tear. There is a partial biceps tendon tear and an anterior band of the inferior glenohumeral ligament tear.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated surgical services: Cold Therapy Unit: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC), 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 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 there is no specification of length of time requested postoperatively for the cryotherapy unit. Therefore, the determination is for non-certification.

**Associated surgical services: Ultrasling:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

**Decision rationale:** According to the California MTUS guidelines, Shoulder complaints Chapter 9 pages 212-214, it is recommended to use a brief use of the sling for severe shoulder pain (1-2 days) with pendulum exercises to prevent stiffness and cases of rotator cuff conditions, and prolonged use of the sling only for symptom control is not supported. In this case the use of a shoulder sling would be contraindicated following right shoulder arthroscopy to prevent adhesive capsulitis. The request for a sling is therefore not medically necessary and appropriate.

**Associated surgical services: Shoulder Continuous Passive Motion (CPM):** 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) Treatment in Workers Compensation (TWC)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Continuous passive motion (CPM).

**Decision rationale:** CA MTUS/ACOEM guidelines are silent on the issue of CPM machine. According to the Official Disability Guidelines, Shoulder Chapter, Continuous passive motion (CPM), CPM is recommended for patients with adhesive capsulitis but not with patients with rotator cuff pathology primarily. With regards to adhesive capsulitis it is recommended for 4 weeks. As there is no evidence preoperatively of adhesive capsulitis in the cited records, the determination is for non-certification.