

<b>Case Number:</b>	CM15-0123454		
<b>Date Assigned:</b>	07/07/2015	<b>Date of Injury:</b>	03/10/2014
<b>Decision Date:</b>	08/04/2015	<b>UR Denial Date:</b>	06/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/26/2015

### 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 71 year old male who sustained an industrial injury on 3/10/14. The mechanism of injury was lifting per utilization review. He currently complains of right elbow and right shoulder pain with swelling and decreased range of motion. On physical exam of the right shoulder there was positive empty can test, positive impingement test; the right elbow was tender to palpation at lateral aspect with clicking. Medication was ibuprofen. Diagnoses include status post arthroscopic triangular fibrocartilage complex repair (11/20/14); lateral epicondylitis (per utilization review). Treatments to date include medication which helps with short-term relief; right wrist immobilizer. The note dated 6/8/15 was indecipherable regarding treatment plan. On 6/18/15 Utilization Review evaluated a request for purchase of Coreflex brace; shoulder sling; cold therapy unit with pad.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One purchase of Coreflex brace:** 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 Index, 11th Edition (Web), 2014, Shoulder, Immobilization.

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

**Decision rationale:** The claimant sustained a work injury and March 2014 and underwent arthroscopic left wrist surgery in November 2014. He also right shoulder pain with findings of a full thickness right rotator cuff tear. An arthroscopic subacromial decompression with rotator cuff repair is being planned. When seen, imaging results were reviewed. He was having ongoing pain, swelling, and decreased shoulder range of motion. Physical examination findings included tenderness and swelling with positive impingement testing and decreased strength. Empty can testing and Belly press tests were positive. There was right elbow swelling with lateral tenderness and clicking with range of motion. Bracing or splinting is recommended only as short- term initial treatment for lateral epicondylitis in combination with physical therapy / exercise. In this case, a plan for adjunctive exercise is not documented and therefore the request was not medically necessary.

**One purchase of shoulder sling:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Treatment Index, 11th Edition (Web), 2014, Shoulder, 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), Immobilization.

**Decision rationale:** The claimant sustained a work injury and March 2014 and underwent arthroscopic left wrist surgery in November 2014. He also right shoulder pain with findings of a full thickness right rotator cuff tear. An arthroscopic subacromial decompression with rotator cuff repair is being planned. When seen, imaging results were reviewed. He was having ongoing pain, swelling, and decreased shoulder range of motion. Physical examination findings included tenderness and swelling with positive impingement testing and decreased strength. Empty can testing and Belly press tests were positive. There was right elbow swelling with lateral tenderness and clicking with range of motion. Immobilization is not recommended as a primary treatment for the shoulder Benefits of mobilization include earlier return to work, decreased pain, swelling, and stiffness, and a greater preserved range of joint motion, with no increased complications. Immobilization is also a major risk factor for developing adhesive capsulitis. The requested shoulder sling was not medically necessary.

**One purchase of cold therapy unit with pad:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Treatment Index, 11th Edition (Web), 2014, Shoulder, 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 claimant sustained a work injury and March 2014 and underwent arthroscopic left wrist surgery in November 2014. He also right shoulder pain with findings of a full thickness right rotator cuff tear. An arthroscopic subacromial decompression with rotator cuff repair is being planned. When seen, imaging results were reviewed. He was having ongoing pain, swelling, and decreased shoulder range of motion. Physical examination findings included tenderness and swelling with positive impingement testing and decreased strength. Empty can testing and Belly press tests were positive. There was right elbow swelling with lateral tenderness and clicking with range of motion. Continuous-flow cryotherapy is recommended as an option after surgery. Postoperative use generally may be up to 7 days including home use. In this case, purchase of a unit for indefinite was requested which was not medically necessary.