

<b>Case Number:</b>	CM14-0167212		
<b>Date Assigned:</b>	10/14/2014	<b>Date of Injury:</b>	12/16/2012
<b>Decision Date:</b>	12/02/2014	<b>UR Denial Date:</b>	09/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/10/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery, has a subspecialty in Hand Surgery and is licensed to practice in Texas & Georgia. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 38 year old female who reported an injury on 01/06/2013. The injury reportedly occurred while she was emptying a pallet and pulled down on the pallet, causing injury to her left shoulder. She is diagnosed with left shoulder impingement syndrome and distal clavicle arthrosis. Her past treatments included medications, physical therapy, and subacromial cortisone injections. Her diagnostic studies included an MRI of the left shoulder which was performed on 07/18/2013 and revealed mild acromioclavicular osteoarthritis and mild infraspinatus tendonitis. No pertinent surgical history was provided. On 08/18/2014, the injured worker reported persistent moderate left shoulder subacromial pain. Upon physical examination of her left shoulder, her range of motion showed 160 degrees of forward flexion, 150 degrees of abduction, 70 degree of external rotation, and internal rotation was to T10. The injured worker was noted to have a positive Neer impingement, Hawkins impingement and Jobe tests during the rotator cuff exam. The treatment plan included surgery, continuation of self-directed exercises and follow up medical care in 4 weeks. A request for Ultrasling and Shoulder CPM (continuous passive motion) was submitted, however, the rationale was not provided. A Request for Authorization was not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultrasling:** 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), Postoperative abduction pillow sling; Immobilization

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

**Decision rationale:** The request for Ultrasling is not medically necessary. The injured worker reported shoulder pain and the treating physician recommend she have surgery. The Official Disability Guidelines recommend an abduction pillow sling as an option following open repair of large and massive rotator cuff tears. There is no evidence that the injured worker has had surgery to her left shoulder or that open surgical repair of a massive rotator cuff tear was planned within the near future. The requesting physician's rationale for the request is not indicated within the provided documentation. Therefore, the request is not supported. As such, the request is not medically necessary.

**Shoulder CPM (continuous passive motion):** 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), Continuous passive motion (CPM)

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

**Decision rationale:** The request for Shoulder CPM (continuous passive motion) is not medically necessary. The injured had a positive Neer impingement, Hawkins impingement and Jobe tests during the rotator cuff exam. The Official Disability Guidelines do not recommend continuous passive motion for shoulder rotator cuff problems but for adhesive capsulitis. Additionally, the guidelines do not recommend continuous passive motion for after shoulder surgery or for non-surgical treatment of rotator cuff tears. There was no indication that the injured worker had adhesive capsulitis. The clinical documentation suggested the injured worker had rotator cuff problems and the provider recommended shoulder surgery as well; however the guidelines do not recommend the use of continuous passive motion for rotator cuff tears. Therefore, the request cannot be supported at this time. As such, the request is not medically necessary.