

<b>Case Number:</b>	CM14-0083714		
<b>Date Assigned:</b>	07/21/2014	<b>Date of Injury:</b>	04/01/2013
<b>Decision Date:</b>	08/27/2014	<b>UR Denial Date:</b>	05/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2014

### 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 Orthopaedic Surgery and is licensed to practice in California. 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:

This 40-year-old female laborer sustained an industrial injury on 4/1/13, due to repetitive lifting. The 6/20/13 left shoulder MRI impression documented moderate improvement and tendinosis of the rotator cuff with a small tear. Records indicated the patient was overweight with a negative past medical history. The 4/23/14 orthopedic report cited left greater than right shoulder pain. Pain increased with reaching overhead, going through an awkward motion, and lifting. There was pain at night. Conservative treatment had included physical therapy, anti-inflammatories, and steroid injections with only temporary relief of pain. Left shoulder exam findings documented tenderness of the anterior acromial margin and acromioclavicular joint. Range of motion testing documented flexion 175, abduction 170, external rotation 80, and internal rotation 75 degrees. Speed's and impingement tests were positive. There was pain with resisted external rotation. Drop arm and apprehension tests were negative. There was no atrophy. The left shoulder MRI showed downsloping of the anterolateral acromion with impingement, bursitis and tendonitis, and a small partial thickness tear. The treatment plan recommended left shoulder arthroscopy with subacromial decompression and debridement versus repair of the rotator cuff. The 5/7/13 utilization review certified the associated request for left shoulder arthroscopic surgery. The request for a sling with pillow was denied as the patient did not meet guideline criteria for use. The pre-operative clearance was denied as there was no rationale to support referral for this service.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 sling w/pillow:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Post-operative abduction pillow sling.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205, 213. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) SHOULDER, POSTOPERATIVE ABDUCTION PILLOW SLING.

**Decision rationale:** The California MTUS are silent regarding post-op pillow slings. The Official Disability Guidelines state that these slings are recommended as an option following open repair of large and massive rotator cuff tears. Guideline criteria have not been met. This patient has a small partial rotator cuff tear and arthroscopic repair is planned. Guidelines generally support a standard sling for post-operative use. There is no compelling reason to support the medical necessity of a specialized abduction sling over a standard sling. Therefore, this request for purchase of one sling with a pillow is not medically necessary.

**Pre-operative clearance:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute & Chronic) Preoperative clearance Surgery General Information and Ground Rules, California Official Medical Fee Schedule, 1999 edition, pages 92-93.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation.

**Decision rationale:** Under consideration is a request for pre-operative medical clearance. The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Guideline criteria have been met given the risks of undergoing anesthesia. Middle-aged females who are overweight have known occult increased medical and cardiac risk factors. Therefore, this request for pre-operative clearance is medically necessary.