

<b>Case Number:</b>	CM14-0206324		
<b>Date Assigned:</b>	12/18/2014	<b>Date of Injury:</b>	07/11/2014
<b>Decision Date:</b>	03/05/2015	<b>UR Denial Date:</b>	12/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/09/2014

### 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, Sports Medicine

### 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 37-year-old male who reported an injury on 07/11/2014. The mechanism of injury was not specifically stated. The current diagnoses include status post industrial left shoulder injury and high grade partial thickness intrasubstance infraspinatus tendon tear with AC joint degenerative joint disease and possible superior labral tear. The injured worker presented on 11/21/2014 with complaints of left shoulder pain. Previous conservative treatment includes physical therapy and a cortisone injection. On examination, there was a positive Hawkins and Neer impingement sign with pain with cross body adduction, pain with terminal range of motion, and negative instability. It was noted that the injured worker was an excellent candidate for a left shoulder arthroscopic evaluation, subacromial decompression, distal clavicle resection, and labral/cuff debridement versus repair. A Request for Authorization form was then submitted on 12/01/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pre-Op Clearance:** 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)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Preoperative testing, general.

**Decision rationale:** The Official Disability Guidelines state preoperative testing is often performed before surgical procedures. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. There was no mention of comorbidities or a significant medical history. The medical necessity for preoperative testing has not been established in this case. As such, the request is not medically appropriate.

**E-Stim:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

**Decision rationale:** California MTUS Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1 month home based trial may be considered as a noninvasive conservative option. TENS therapy is recommended in the postoperative period for the first 30 days. Rental is preferred over purchase during the 30 day period. There was no specific duration listed in the current request. It is unclear whether the request is for an E-stim unit purchase or rental. Therefore, the request is not medically appropriate.

**Sling with Large Abductions Pillow:** 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)

**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, Postoperative abduction pillow sling.

**Decision rationale:** The Official Disability Guidelines recommend a postoperative abduction pillow sling following open repair of large and massive rotator cuff tears. They are not recommended for arthroscopic repairs. As such, the current request is not medically appropriate, as the injured worker is not scheduled to undergo a large and massive rotator cuff repair.

**CPM Unit:** 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)

**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.

**Decision rationale:** The Official Disability Guidelines recommend continuous passive motion for adhesive capsulitis. It is not recommended after shoulder surgery or for nonsurgical treatment. Therefore, the current request cannot be determined as medically appropriate in this case. There was also no specific duration of treatment listed in the request.