

<b>Case Number:</b>	CM14-0046128		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	12/16/2007
<b>Decision Date:</b>	04/23/2015	<b>UR Denial Date:</b>	04/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/15/2014

### 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: Physical Medicine & Rehabilitation

### 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 male, who sustained an industrial injury on 1/18/10. The injured worker was diagnosed as having chronic left frozen shoulder with underlying partial rotator cuff tendon tears, right frozen shoulder and brittle diabetes. Treatment to date has included physical therapy and status post left shoulder arthroscopy with decompression and manipulation under anesthesia without capsulectomy. (MRI) magnetic resonance imaging of left shoulder was performed on 2/24/14. Currently, the injured worker complains of difficulty managing blood sugars and shoulder problems. Treatment plan included left shoulder arthroscopy, capsulectomy and manipulation under anesthesia. It is noted on 9/16/13, the frozen shoulders were improving with physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultrasling left shoulder:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints  
Page(s): 204.

**Decision rationale:** The patient was injured on 12/16/2007 and presents with shoulder problems. The request is for an ULTRASLING OF THE LEFT SHOULDER. The utilization review denial rationale is that "the surgical intervention has been deemed not medically necessary based on the documentation presented for review." There is no RFA provided and the patient's work status is not known. ACOEM Guidelines shoulder chapter, chapter 9 page 204 under options, it allows for "sling for acute pain" under rotator cuff tear and as a "sling for comfort," for AC joint strain or separation. The 03/21/2014 report states that the patient had an MRI obtained on 02/24/2014 which revealed evidence of partial supraspinatus and subscapularis tendon tears. He has significant loss of the glenohumeral space suggestive of adhesive capsulitis. The patient is diagnosed with the following: 1.Chronic left frozen shoulder with underlying partial rotator cuff tendon tears involving the supraspinatus and subscapularis (status post previous arthroscopy at Kaiser with subacromial decompression and manipulation under anesthesia without capsulectomy). 2.Right frozen shoulder.3.Brittle diabetes with difficulty with management of the issue. The patient underwent a left shoulder arthroscopy, manipulation, anesthesia, and subacromial decompression on 07/29/2008. Given that the patient has a frozen left shoulder with underlying partial rotator cuff tendon tears involving the supraspinatus and subscapularis, the requested left shoulder UltraSling is medically necessary.