

<b>Case Number:</b>	CM14-0140494		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	01/14/1993
<b>Decision Date:</b>	10/31/2014	<b>UR Denial Date:</b>	08/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/29/2014

### 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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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 64-year-old female who reported an injury on 01/14/1993. The mechanism of injury was not provided. The injured worker's diagnoses included a left shoulder rotator cuff tear. The injured worker's past treatments included physical therapy and medications. Her diagnostic testing included an MRI from 06/2009, which was noted to reveal a split tear of the biceps and tendinopathy of the rotator cuff. The injured worker's surgical history included a left shoulder surgery in 02/2011. She had a left shoulder arthroscopic revision surgery in 04/2014. On 05/29/2014, the injured worker reported that she continued to have significant pain status post- surgical repair of the shoulder. She reported that her current medications allowed her to carry out activities of daily living such as cooking, cleaning, laundering, standing, and ambulating for prolonged periods. Upon physical examination, the injured worker was noted to have significantly decreased range of motion of the left shoulder. She could abduct and forward flex to about 90 degrees. She had significantly decreased external rotation. The injured worker's medications included Percocet 10/325 mg, Effexor XR 75 mg, Lunesta 3 mg, Lidoderm 5% patch, Colace 100 mg and Reglan 10 mg. The request was for a stable sling for the left shoulder. The rationale for the request was not provided. The Request for Authorization form was signed and submitted on 06/06/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro stable sling, left shoulder L3670 (purchase): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

**Decision rationale:** The request for retro stable sling, left shoulder L3670 (purchase) is not medically necessary. The California MTUS/ACOEM Guidelines state that brief use of a sling for severe shoulder pain (1 to 2 days) with pendulum exercises is recommended to prevent stiffness in cases of rotator cuff conditions. The injured worker was documented to have used the sling initially. Prolonged use of a sling only for symptom control is not recommended. In the absence of documentation with sufficient evidence of a new shoulder dislocation and reduction, acromioclavicular (AC) separation, or severe sprain, the request is not supported. Therefore, the request is not medically necessary.