

<b>Case Number:</b>	CM14-0216512		
<b>Date Assigned:</b>	01/09/2015	<b>Date of Injury:</b>	02/05/2013
<b>Decision Date:</b>	03/05/2015	<b>UR Denial Date:</b>	12/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/26/2014

### 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 36-year-old male who reported an injury on 02/05/2013 due to an unspecified mechanism of injury. On 11/10/2014, he presented for a followup evaluation regarding his right shoulder. It was stated that he had completed more therapy with improvement in range of motion, and continued with his home exercises. He stated that his left shoulder continued to remain symptomatic and was bothering him, and that he was not able to perform above the shoulder height activities. He rated his left shoulder pain at an 8/10. An examination of the left shoulder showed no gross deformity, no masses or swelling, and no cutaneous abnormalities. There was a decrease in range of motion, a positive Neer's sign, positive Hawkins, and positive arc of rotation. Strength was a 4/5 with abduction and forward flexion. He was diagnosed with left shoulder impingement syndrome. The treatment plan was for the injured worker to continue physical therapy and request a left shoulder arthroscopic decompression with Mumford procedure. The Request for Authorization and rationale for treatment was not provided for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-Operative: Ultra Sling for left shoulder:** 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) Post operative abduction pillow sling

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

**Decision rationale:** The Official Disability Guidelines recommend the use of shoulder slings following repair of a large/massive rotator cuff tear. Based on the clinical information submitted for review, a request was being put in for the injured worker to undergo a left shoulder arthroscopic decompression with Mumford procedure for left shoulder impingement syndrome. However, the guidelines do not support the use of postoperative slings following this type of surgery. There is no documentation that the injured worker has a large and massive rotator cuff tear being repaired, and therefore, the request would not be supported. As such, the request is not medically necessary.