

<b>Case Number:</b>	CM13-0026478		
<b>Date Assigned:</b>	11/22/2013	<b>Date of Injury:</b>	10/22/2012
<b>Decision Date:</b>	02/18/2014	<b>UR Denial Date:</b>	09/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/19/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic 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 physician 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 patient is a 27 year old injured worker with an industrial injury of 10/22/12. The claimant reports pain to the left shoulder. Exam note dated 8/12/13, demonstrates partial tear of anterior band of inferior glenohumeral ligament. Medical records indicate left shoulder positive labral signs and ligamentous laxity, and positive impingement signs of the left shoulder. MRI arthrogram left shoulder, dated 2/8/13, demonstrates no evidence of labral or rotator cuff tear. Exam note dated 8/5/13, demonstrates report of positive impingement signs. Medical records also indicate left shoulder instability with ligamentous laxity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **Left shoulder diagnostic arthroscopy, quantity 1: 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:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**Decision rationale:** According to the California MTUS Shoulder Complaints Chapter, "Referral for surgical consultation may be indicated for patients who have: Red-flag conditions (e.g., acute rotator cuff tear in a young worker, glenohumeral joint dislocation, etc.); Activity limitation for more than four months, plus existence of a surgical lesion; Failure to increase ROM and strength

of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion; and clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair. Surgical considerations depend on the working or imaging-confirmed diagnosis of the presenting shoulder complaint. If surgery is a consideration, counseling regarding likely outcomes, risks and benefits, and expectations, in particular, is very important. If there is no clear indication for surgery, referring the patient to a physical medicine practitioner may help resolve the symptoms. For postsurgical rehabilitation, key indicators for further assessment and treatment include: prolonged course, multiple surgical procedures, and use of narcotic medications. Based upon the lack of documentation of a surgical lesion in this case, the request cannot be supported. The request for left shoulder diagnostic arthroscopy, quantity 1, is not medically necessary and appropriate.

**Left shoulder arthroscopic SLAP repair, quantity 1: 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:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**Decision rationale:** According to the ACOEM Guidelines, regarding Superior Labral Anterior Posterior and Labral tear, "Arthroscopic or open surgery is recommended for treatment of labral or superior labral anterior posterior (SLAP) tears. Indications: Symptoms, MRA or MRI findings and clinical suspicion of labral or SLAP tear that does not resolve after approximately 4 to 6 weeks of non-operative treatment. Most individuals over age 40 do not appear to require surgical repair, although a minority that fail to either resolve or trend towards resolution may need operative repair." The medical records provided for review did not include a surgical lesion on MR arthrogram imaging. The request for a left shoulder arthroscopic SLAP repair, quantity 1, is not medically necessary and appropriate.

**Pre-operative antibiotics (medication dosage and quantity not specified) quantity 1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Pre-operative appointment with PA, quantity 1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**DME (Type of DME and duration of use not specified) quantity 1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Physical therapy referral (number of visits not specified):** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.