

<b>Case Number:</b>	CM14-0088949		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	04/03/2013
<b>Decision Date:</b>	09/09/2014	<b>UR Denial Date:</b>	05/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/12/2014

### 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 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 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 claimant is a 41-year-old female who injured her left shoulder in work related accident on 04/03/13. Records provided for review document that the claimant underwent left shoulder arthroscopy, subacromial decompression, debridement of labral tearing on 02/12/14. The postoperative clinical records include the 07/10/14 reassessment describing continued complaints of pain in the neck and left shoulder. Examination of the left shoulder revealed 160 degrees of flexion, 140 degrees of abduction, tenderness over the acromioclavicular joint and pain with cross arm testing. There was positive O'Brien's testing and impingement signs. It is documented that physical therapy has been utilized in the postoperative setting. There is no documentation of postoperative imaging for review. This review is for the surgical procedure of left shoulder subacromial decompression and evaluation of SLAP cyst.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder arthroscopic subacromial decompression with arthroscopic evaluation of a SLAP cyst:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Official Disability Guidelines Treatment in Worker's Comp , 18th Edition, 2013 Updates:  
shoulder procedure -Surgery for SLAP lesions.

**Decision rationale:** Based on California ACEOM Guidelines and supported by the Official Disability Guidelines, the proposed left shoulder arthroscopic subacromial decompression with arthroscopic evaluation of a SLAP cyst criteria is not recommended as medically necessary. The medical records document that the claimant recently had a February, 2014, surgery for the left shoulder for which a decompression took place. Postoperatively, there is no documentation imaging or conservative measures that would have included three to six months of care including injection therapy. There is presently no indication for a second surgical process for this individual's left shoulder as requested.

**Norco 10/325mg QTY: 90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91.

**Decision rationale:** The request for left shoulder arthroscopic subacromial decompression with arthroscopic evaluation of a SLAP cyst is not recommended as medically necessary. Therefore, the request for postoperative physical therapy for the left shoulder is also not medically necessary.

**Post-op physical therapy 2 x 6 (2 times per week for 6 weeks) for the left knee:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** California MTUS postsurgical rehabilitative guidelines would not support physical therapy for the claimant's shoulder. Specific request in this case was for the claimant's "knee;" however, there is no documentation of any left knee related findings or surgery having been performed. Without documentation of need for further surgical process there would be no indication for postoperative physical therapy in this individual.