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| <b>Case Number:</b>   | CM15-0018108 |                              |            |
| <b>Date Assigned:</b> | 02/06/2015   | <b>Date of Injury:</b>       | 09/20/2014 |
| <b>Decision Date:</b> | 04/01/2015   | <b>UR Denial Date:</b>       | 01/24/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/30/2015 |

### 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 53-year-old male who reported an injury on 09/20/2014. The mechanism of injury was not specifically stated. The current diagnoses include rule out rotator cuff tear and shoulder impingement. The injured worker presented on 11/14/2014 for a follow-up evaluation. It was noted that the injured worker was status post decompression and rotator cuff repair involving the right shoulder several years ago with an excellent outcome. The injured worker reported pain at night, weakness, and catching of the left shoulder. Upon examination, there was anterior, posterior, and lateral tenderness of the left shoulder with positive impingement and Hawkins' maneuver. There was also positive O'Brien's test, positive Speed's and Whipple Test, positive SST, and positive resisted external rotation test. Recommendations at that time included an MRI of the left shoulder and continuation of Norco 10/325 mg and ibuprofen 200 mg. A Request for Authorization form was submitted on 01/16/2015 for an arthroscopic SLAP repair with postoperative physical therapy 2 to 3 times per week for 4 to 6 weeks. It was also noted that the injured worker underwent an MRI of the left shoulder on 11/20/2014, which revealed evidence of a SLAP tear with cystic change in the posterior labrum and a 4 mm adjacent paralabral cyst. There was moderate acromioclavicular joint osteoarthritis and tendinosis of the distal supraspinatus tendon without rotator cuff tear.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Arthroscopic slap repair surgery: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints  
Page(s): 209-210.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicated for patients who have red flag conditions, activity limitation for more than 4 months, failure to increase range of motion and strength after exercise programs, and who have clear clinical and imaging evidence of a lesion. In this case, it was noted that the injured worker had imaging evidence consistent with a SLAP tear. However, there was no documentation of an attempt at any conservative treatment prior to the request for a surgical procedure. Therefore, the request is not medically appropriate at this time.

**18 Post-op physical therapy sessions: 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.