

<b>Case Number:</b>	CM15-0025337		
<b>Date Assigned:</b>	02/17/2015	<b>Date of Injury:</b>	08/31/2008
<b>Decision Date:</b>	04/01/2015	<b>UR Denial Date:</b>	01/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/10/2015

### 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: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 60-year-old male who sustained an industrial injury on 8/31/07. Records documented increasing left shoulder pain with range of motion restriction, fairly constant over the past 2 years. There was no documentation of conservative treatment. The 11/19/14 left shoulder MRI Impression documented a focus of hydroxyapatite deposition disease involving the posterior supraspinatus tendon, superior labral tear, and severe glenohumeral degenerative arthrosis with undersurface osteophytes indenting the adjacent supraspinatus musculotendinous junction. The 12/16/14 treating physician report indicated that the patient had had an MRI since his last visit. He was still having anterior and posterior left shoulder pain, including pain at night. Pain was reported moderate, and aggravated by lying on his stomach, pushing, pulling, activities, and lifting any overhead weights. Physical exam documented no change in range of motion with flexion 180 and external rotation 50 degrees, and internal rotation to T9. Speed's and O'Brien's tests were positive. Hawkin's, cross body abduction, O'Driscoll's, and biceps load tests were negative. MRI showed a SLAP tear. The treatment plan recommended arthroscopic evaluation and treatment for the SLAP tear. The patient was retired. On 1/19/15, utilization review non certified left shoulder arthroscopy SLAP repair, debridement as indicated, cold therapy unit and Donjoy Ultrasling 2, postoperative physical therapy x 18, preoperative medical clearance, EKG, and labs citing the MTUS and ACOEM guidelines. The rationale for non-certification of the left shoulder arthroscopy noted an absence of recent conservative treatment trial and the patient's age.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Left Shoulder Arthroscopy SLAP Repair, Debridement as indicated: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for SLAP lesion.

**Decision rationale:** The California MTUS guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. The Official Disability Guidelines recommend surgery for SLAP lesions after 3 months of conservative treatment for Type II or IV lesions, when history and physical exam and imaging indicate pathology. Guideline criteria have not been met. This patient presents with chronic moderate left shoulder pain. Clinical exam findings are consistent with imaging evidence of a SLAP tear. Additionally, the patient is noted with hydroxyapatite deposition disease and potential impingement syndrome. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, including injection, and failure has not been submitted. Therefore, this request is not medically necessary at this time.

### **Cold Therapy Unit and Donjoy Ultraling 2: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Continuous flow cryotherapy; Postoperative abduction pillow sling.

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

### **18 Sessions of Post-op Physical Therapy: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

**Pre-op Medical Clearance:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

**EKG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38.

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.

**Labs:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38.

**Decision rationale:** As the surgical request is not supported, this request is not medically necessary.