

<b>Case Number:</b>	CM14-0012378		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	09/15/2011
<b>Decision Date:</b>	08/11/2014	<b>UR Denial Date:</b>	01/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/30/2014

### 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 Physical Medicine and Rehabilitation 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 patient is a 62-year-old female who has submitted a claim for right shoulder adhesive capsulitis and impingement, cervical and lumbar disc degenerative disease, right hip trochanteric bursitis, myofascial pain syndrome, gastritis, borderline hypertension, and anxiety associated with an industrial injury date of 9/15/2011. The Medical records from 2013 to 2014 were reviewed. Patient complained of neck and right shoulder pain radiating to the right arm, wrist, and hand, graded 7-8/10 in severity. Patient likewise experienced popping sensation at the right shoulder, associated with restricted movement. Aggravating factors included repetitive pushing, pulling, lifting, carrying, and reaching. Physical examination of the right shoulder revealed restricted range of motion, and tenderness. There was inability to test for impingement sign due to pain. Subluxation / apprehension test was negative. Atrophy and hyporeflexia were not noted. Jamar hand dynamometer revealed grip strength of 22/27/25 at the right, and 38/35/32 at the left. Of note, patient is right-hand dominant. Sensation was diminished at the right median nerve distribution. A report, dated 2/3/14, cited that patient was unable to attend physical therapy sessions due to lack of transportation. Progress report from 12/18/2013 ordered for updated MRI of the right shoulder prior to surgery; it was authorized on 1/15/2014. Official result was not made available for review. A MRI of the right shoulder, dated 2/22/12, revealed partial tear involving less than 50% of the infraspinatus tendon, tendinosis of the supraspinatus and infraspinatus, and mild osteoarthritis of the acromioclavicular joint. X-ray of the right shoulder, dated 12/18/2013, revealed osteoarthritis of the acromioclavicular joint. The treatment to date has included extracorporeal shockwave treatment, acupuncture, three cortisone injections to the right shoulder, and medications such as, Prozac, Lyrica, Robaxin, Ambien, Colace, Imitrex, and Norco. A utilization review from 1/23/2014 denied the request for right shoulder arthroscopic release with subacromial decompression and distal clavicle excision because there

was no detailed evidence of recent conservative treatment. Therefore, all of the associated requests such as: pre-op clearance, post-op follow up, arm sling, post op narcotic pain medication Norco 5/325 mg, post op physical therapy 2 x 6, and right shoulder manipulation under anesthesia were likewise non-medically necessary.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **RIGHT SHOULDER ARTHROSCOPIC CAPSULE RELEASE WITH SUBACROMIAL DECOMPRESSION AND DISTAL CLAVICLE EXCISION: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

**Decision rationale:** The CA MTUS ACOEM Chapter 9 pages 209-210 indicates that arthroscopic surgery and decompression for the shoulder may be considered reasonable and necessary if there is activity limitation for more than 4 months, failure to increase range of motion 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. In this case, patient complained of persistent right shoulder pain described as popping sensation. Physical examination revealed restricted range of motion, tenderness, and inability to test for impingement sign due to pain. Subluxation / apprehension test and atrophy were not evident. Pain was reported to be persistent despite chiropractic care, cortisone injections, physical therapy, and intake of medications. However, a report from 2/3/14 cited that patient was unable to attend to physical therapy sessions due to lack of transportation. Hence, it is unclear if there is failure of conservative management because the number of physical therapy sessions attended was not documented. MRI of the right shoulder, dated 2/22/12, revealed partial tear involving less than 50% of the infraspinatus tendon, and tendinosis of the supraspinatus and infraspinatus. Progress report from 12/18/2013 requested for updated MRI prior to surgery; it was authorized on 1/15/2014. However, official result was not made available for review. The medical necessity for surgery was not established at this time due to lack of information concerning MRI results and failure of conservative care. Therefore, the request for RIGHT SHOULDER ARTHROSCOPIC CAPSULE RELEASE WITH SUBACROMIAL DECOMPRESSION AND DISTAL CLAVICLE EXCISION is not medically necessary.

**PRE-OP CLEARANCE: 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, the associated services are not medically necessary.

**POST-OP FOLLOW UP:** 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, the associated services are not medically necessary.

**ARM SLING:** 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, the associated services are not medically necessary.

**POST OP NARCOTIC PAIN MEDICATION NORCO 5/325 MG:** 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, the associated services are not medically necessary.

**POST OP PHYSICAL THERAPY 2 X 6:** 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, the associated services are not medically necessary.

**RIGHT SHOULDER MANIPULATION UNDER ANESTHESIA:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Section, Manipulation under Anesthesia.

**Decision rationale:** The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG) was used instead. ODG criteria for manipulation under anesthesia include adhesive capsulitis refractory to conservative therapy lasting at least 3-6 months where abduction remains less than 90. In this case, patient complained of persistent right shoulder pain described as popping sensation. Physical examination revealed restricted range of motion, tenderness, and inability to test for impingement sign due to pain. Pain was reported to be persistent despite chiropractic care, cortisone injections, physical therapy, and intake of medications. However, a report from 2/3/14 cited that patient was unable to attend to physical therapy sessions due to lack of transportation. Hence, it is unclear if there is failure of conservative management because the number of physical therapy sessions attended was not documented. Moreover, right shoulder abduction was measured at 100 degrees in a report dated 2/3/14. Guideline criteria were not met. Therefore, the request for RIGHT SHOULDER MANIPULATION UNDER ANESTHESIA is not medically necessary.