

<b>Case Number:</b>	CM14-0086312		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	11/26/2012
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	05/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2014

### 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 Pennsylvania. 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 68 year old female who sustained a vocational injury on 11/26/12. The medical records provided for review document a working diagnosis of left shoulder internal derangement, left shoulder current tear, cervical strain; status post left shoulder surgery, left rotator cuff tear, left shoulder pain, left shoulder pain/strain. The office note dated 07/08/14 described continued left shoulder pain, worse with activities. Examination revealed tenderness upon palpation of the left shoulder, left shoulder range of motion was decreased in all directions, and muscle strength was 5/5 in all limbs. There was also decreased sensation to touch at the shoulder, left anterior bicep, left wrist. The report of an MRI of the left shoulder dated 12/23/13 identified during the injection of gadolinium, the claimant experienced pain and discomfort. There was extravasation of contrast into the tissue from the joint capsule at the level of the subscapularis. The claimant's symptoms during the injection suggested adhesive capsulitis. Abnormal contour of the inferior labrum was noted at the level of axillary recess and the presence of a small tear could not be excluded. There was post-operative status of the humeral head appreciated. Conservative treatment to date includes formal therapy, occupational therapy, a previous left rotator cuff tear with post-operative physical therapy, six sessions of acupuncture, and medications. The current request is for a left shoulder arthroscopic lysis of adhesions, capsular release and rotator cuff repair.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Shoulder Arthroscopic Lysis of Adhesions, Capsular Release and Rotator Cuff Repair: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Shoulder chapter: Surgery for adhesive capsulitis.

**Decision rationale:** California MTUS ACOEM and Official Disability Guidelines do not support the request for left shoulder arthroscopic lysis of adhesions, capsular release of rotator cuff repair as medically necessary. Documentation presented for review suggests the claimant has had a minimal amount of formal physical therapy to date. California MTUS ACOEM Guidelines note that prior to considering surgical intervention for the current working diagnosis, there should be documentation of failure to increase range of motion and muscular strength with exercise programs plus there should be the existence of a surgical lesion. In addition, there should be clear clinical imaging evidence of a lesion that has shown the benefit in both the short and long term from surgical repair. There should be documented activity limitations for more than four months plus the existence of a surgical lesion. Documentation presented for review fails to establish claimant has undergone a recent exhaustive course of conservative treatment which should include a minimum of three to six months continuous conservative treatment in the form of home exercise program, formal physical therapy, anti-inflammatories, activity modification, and corticosteroid injections. In addition, there is a lack of abnormal objective physical exam findings suggesting that surgical intervention would be medically warranted. Therefore, based on the documentation presented for review and in accordance with California MTUS ACOEM and Official Disability Guidelines, the request for left shoulder arthroscopic lysis of adhesions, capsular release of rotator cuff repair cannot be considered medically necessary.

**Electromyogram Left Upper Extremity:**

**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 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Neck and Upper Back chapter: Electrodiagnostic studies (EDS), Nerve conduction studies (NCS), and Electromyography (EMG).

**Decision rationale:** The California MTUS ACOEM and Official Disability Guidelines do not support the request for an electromyogram of the left upper extremity. California MTUS ACOEM Guidelines note that there should be documentation of failure to progress in a strengthening program intended to avoid surgery. In addition, there should be physiologic evidence in the form of definitive neurologic findings on physical exam prior to considering

further work-up with diagnostic testing in the form of EMG and nerve conduction studies. Prior to considering further diagnostic testing, both California MTUS ACOEM and Official Disability Guidelines also suggest the claimant should have attempted, failed and exhausted traditional courses of first-line conservative treatment. The request cannot be recommended as medically necessary.

**Nerve Conduction Studies of the Left Upper Extremity: 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 2 General Approach to Initial Assessment and Documentation, Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Neck and Upper Back chapter: Electrodiagnostic studies (EDS), Nerve conduction studies (NCS) and Electromyography (EMG).

**Decision rationale:** The California MTUS ACOEM and Official Disability Guidelines do not support the request for a nerve conduction study of the left upper extremity. ACOEM Guidelines recommend that there should be documentation of failure to progress in a strengthening program intended to avoid surgery. In addition, there should be physiologic evidence in the form of definitive neurologic findings on physical exam prior to considering further work-up with diagnostic testing in the form of EMG and nerve conduction studies. Prior to considering further diagnostic testing, both California MTUS ACOEM and Official Disability Guidelines also suggest the claimant should have attempted, failed and exhausted traditional courses of first-line conservative treatment. The request for left upper extremity EMG and nerve conduction study cannot be considered medically necessary.

**Butrans Patch 10 mcg, 1 Patch every 7 days #4 with no refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 26-27. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine Page(s): 26-27.

**Decision rationale:** In regards to the request for a Butrans patch, 10 mcg, one patch every seven days, dispensed #4 with no refills; the previous utilization review determination is in February of 2014 documented conservative treatment with Tramadol and Tylenol, along with acupuncture. It is documented that the claimant had a significant decrease in pain. The rationale for the use of a Butrans patch over the tablets is not clear especially when it is documented that the claimant's pain had decreased. In addition, the abnormal physical exam objective findings presented for review fail to establish that the claimant would require significant opioids for management of current orthopedic and musculoskeletal complaints. Subjective complaints fail to corroborate

with the amount of medication and the type of medication being requested and subsequently, the request cannot be considered medically necessary.