

Case Number:	CM14-0196621		
Date Assigned:	12/04/2014	Date of Injury:	12/20/2011
Decision Date:	01/28/2015	UR Denial Date:	10/27/2014
Priority:	Standard	Application Received:	11/24/2014

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 Minnesota. 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 injured worker is a 51-year-old male with a history of work-related injury to the neck and left shoulder on 12/20/2011. There was radicular pain reported in the scapular area. A shoulder injection of corticosteroids did not result in any improvement.. The pain was also associated with numbness in the hand. The MRI scan of the left shoulder performed on 2/20/2014 revealed complete tear of the supraspinatus tendon with 8 mm retraction, infraspinatus tendinitis, and acromioclavicular arthritis. Arthroscopy of the shoulder was performed on 3/27/2014. The operative report is not provided. Postoperatively he completed the physical therapy sessions as well as acupuncture. A progress note dated 7/9/2014 indicated severe left shoulder pain aggravated by lifting, using the arms, gripping and grasping. Pain radiated down to the hand. On examination there was grade 3 spasm and tenderness in the upper shoulder muscles and rotator cuff muscles. Codman's, Speed's, and supraspinatus testing was positive on the left. Shoulder flexion was 75 and abduction 35. An AME physician recommended a repeat arthroscopy of the left shoulder with lysis of adhesions and manipulation under anesthesia for adhesive capsulitis on 9/3/2014. Recent postoperative imaging was not submitted. The request for a repeat left shoulder arthroscopy was noncertified by utilization review on 10/27/14 based on the absence the AME report and absence of postoperative imaging demonstrating need for arthroscopy. However, since that time the AME report has been submitted. This is dated 9/3/2014 and indicated a prior diagnosis of left paracentral C6-7 disc herniation with left upper extremity radiculitis and a painful left shoulder impingement syndrome on 6/11/2013. There was a prior diagnosis of adhesive capsulitis and impingement syndrome of the left shoulder for which arthroscopy was performed on 3/27/2014 with lysis of adhesions and subacromial decompression and labral debridement. There was a one month delay in the postoperative physical therapy during which time the shoulder stiffened up again. The subjective complaints included pain in

the left side of neck into the left shoulder, continued pain and restricted range of motion of the left shoulder, and pain in the biceps up into the shoulder, left side of neck and left side of head. However, the numbness in the left hand had subsided. Examination findings on 9/3/2014 revealed active abduction of 130 degrees in the left shoulder and 175 in the right shoulder. The recommendation was a repeat arthroscopy and manipulation under anesthesia. No postoperative imaging was documented.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder repeat arthroscopy: 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, Diagnostic arthroscopy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section: Shoulder, Topic: Manipulation under anesthesia, surgery for adhesive capsulitis.

Decision rationale: The documentation indicates a prior diagnosis of adhesive capsulitis and impingement syndrome for which arthroscopy was performed on 3/27/2014. A prior MRI of 2/20/2014 had also revealed a rotator cuff tear but the AME report does not mention a rotator cuff repair performed at the time of surgery. The operative report is not provided. Postoperatively the shoulder was reported to be stiff and painful. There is no recent imaging study documenting a tear of the rotator cuff or labrum or other such pathology warranting additional shoulder surgery. The only current diagnosis pertains to adhesive capsulitis with loss of motion and pain. ODG guidelines consider adhesive capsulitis to be self-limiting and conservative treatment including physical therapy and injections are recommended. Manipulation under anesthesia is recommended for refractory cases after 3-6 months of physical therapy and corticosteroid injections. The AME of 9/3/2014 on page 4 of the 31 page report indicated active abduction of 130 in the left shoulder. On page 5, flexion was 130, and internal rotation 50 and external rotation 50. On palpation there was mild to moderate tenderness of the anterior deltoid, posterior deltoid, greater tuberosity, and bicipital groove, all on the left. Impingement sign was weakly positive. The guidelines for manipulation under anesthesia include abduction of 90 or less. Arthroscopy with lysis of adhesions is indicated when conservative treatment fails. In the absence of a recent imaging study providing evidence of a lesion that is known to benefit both in the short-term and long-term from surgical repair, and in the absence of documentation of 3-6 months of conservative treatment for adhesive capsulitis utilizing corticosteroid injections and physical therapy, the requested procedure of repeat arthroscopy of the left shoulder is not supported by guidelines and as such, the medical necessity of the requested procedure is not substantiated.