

<b>Case Number:</b>	CM15-0131241		
<b>Date Assigned:</b>	07/17/2015	<b>Date of Injury:</b>	10/08/2014
<b>Decision Date:</b>	08/19/2015	<b>UR Denial Date:</b>	06/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/07/2015

### 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: Minnesota, Florida

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 50-year-old male with a date of injury of 10/8/2014. He complains of pain and stiffness in the right shoulder. Per orthopedic note dated 5/21/2015 he has adhesive capsulitis and a rotator cuff tear. According to the notes, he failed to respond to 3 cortisone injections and 12 physical therapy sessions. On examination, there was tenderness over the lateral acromion and pain with impingement testing. Forward elevation was 90° and abduction 60°. External rotation was 0° and internal rotation to the buttock. Strength was well maintained at 4+/5 only limited by pain. The recommendation was to proceed with arthroscopy, capsular release and rotator cuff repair. A prior physical medicine and rehabilitation note dated March 5, 2015 documented an unofficial MRI reading of a small tear of the bursal surface of the rotator cuff 2 mm in diameter, some degenerative labral tearing but otherwise no other remarkable findings except for some thickening of the capsule. The impression was impingement syndrome, small rotator cuff tear, and adhesive capsulitis. A prior orthopedic note dated December 17, 2014 had revealed negative impingement testing. The official MRI report or physical therapy notes have not been submitted. The disputed request is for arthroscopy of the right shoulder with debridement, subacromial decompression, muscle reconstruction, coracoacromial ligament release, surgical repair, and rotator cuff repair. The request was non-certified by Utilization Review citing CA MTUS and ODG guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right Shoulder Debridement, Arthroscopic Subcromial Decompression, Rotator Cuff Repair, Muscle Reconstruction, Coracoacromial Ligament Release and Surgical Repair:**  
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): 210, 211 and 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Surgery for adhesive capsulitis.

**Decision rationale:** California MTUS guidelines indicate the surgery for impingement syndrome is usually arthroscopic decompression. Conservative care including cortisone injections can be carried out for at least 3-6 months before considering surgery. The guidelines recommend 3 months of continuous physical therapy or 6 months of intermittent physical therapy with a home exercise program and 2-3 corticosteroid injections as part of an exercise rehabilitation program for rotator cuff inflammation, impingement syndrome, and small tears. ODG guidelines indicate that adhesive capsulitis is considered self-limiting and conservative treatment including physical therapy and NSAIDs is a good long-term treatment regimen for adhesive capsulitis. Arthroscopic release of adhesions may be indicated in cases failing conservative treatment. With regard to the arthroscopic capsular release, ODG guidelines indicate it is currently unclear as to whether there is a difference in the clinical effectiveness of arthroscopic capsular release compared to manipulation under anesthesia in patients with recalcitrant idiopathic adhesive capsulitis. In this case, although some physical therapy has been documented, the physical therapy notes have not been provided and the exact duration of the continuous physical therapy is not known. In the absence of documented 3-6 months of exercise rehabilitation program subacromial decompression is not indicated. The MRI report has not been provided although some notes indicate a 2 mm rotator cuff tear. The guidelines indicate that a 2 mm rotator cuff tear should be treated the same as impingement syndrome. Surgical repair for a 2mm bursal surface rotator cuff tear is not indicated. ODG guidelines recommend manipulation under anesthesia for management of adhesive capsulitis 6-9 months from the onset of symptoms if the exercise rehabilitation program combined with corticosteroid injections is not effective. Rationale for "muscle reconstruction" and "surgical reconstruction" has not been provided. The coracoacromial ligament release is part of the subacromial decompression and the same guidelines apply. In light of the foregoing, the request for arthroscopy with subacromial decompression, debridement, muscle reconstruction, coracoacromial ligament release, rotator cuff repair, and surgical repair is not supported by evidence-based guidelines and as such, the medical necessity of the request has not been substantiated.

**Surgical Assistant:** 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, none of the associated services are medically necessary.