

Case Number:	CM15-0056481		
Date Assigned:	04/01/2015	Date of Injury:	10/12/2012
Decision Date:	05/06/2015	UR Denial Date:	03/11/2015
Priority:	Standard	Application Received:	03/24/2015

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 32-year-old male with a reported date of injury of 10/12/13. The mechanism of injury was not documented. Past surgical history was positive for a right shoulder arthroscopy with SLAP repair on 1/15/14 and right shoulder manipulation under anesthesia for recalcitrant adhesive capsulitis on 8/27/14. Post-operative extensive physical therapy and continuous passive motion was documented. The 1/19/15 treating physician report indicated that the injured worker had not regained range of motion to a functional degree to allow return to work as a truck driver. He had difficulty with shifting gears and tiedowns. Right shoulder exam documented 0-80 degrees active abduction with 3/5 abduction strength, and active flexion 0-90 degrees with 3/5 flexion strength. Internal rotation with extension was noted to the L5 level. There was no swelling. X-rays were taken and showed normal acromioclavicular (AC) joint relationships and no impingement on the outlet view. There was no osteoarthritis of the glenohumeral joint. The diagnosis included symptomatic adhesive capsulitis, long head biceps tendonitis, and SLAP lesion. A second opinion was requested. The 1/29/15 treating physician report documented MRI findings as relatively normal. There were surgical changes consistent with an anchor placement for the SLAP repair, otherwise no abnormalities. The biceps tendon sat in the bicipital groove. The 3/02/15 orthopedic consult report cited right shoulder pain and limited range of motion with tenderness over the bicipital groove anterior right shoulder. Physical exam documented right shoulder flexion 0-120 degrees and abduction 0-100 degrees. Internal rotation with extension was noted to L5. External rotation with abduction caused pain over the biceps tendon area. Tenderness to palpation was noted over the biceps tendon area. The

diagnosis included symptomatic adhesive capsulitis and long head biceps tendonitis. Authorization was requested for right shoulder arthroscopy with release of the biceps tendon and subacromial decompression for lysis of adhesions to improve range of motion and decrease pain, and assistant surgeon and post-op physical therapy. The 3/11/15 utilization review non-certified the request for right shoulder arthroscopy with subacromial decompression and biceps tendon release and associated requests as there were relative normal imaging and x-ray findings, and no documentation of failed injection therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy, subacromial decompression, and bicep tendon release: Upheld

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

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: Surgery for impingement syndrome; Surgery for adhesive capsulitis.

Decision rationale: The California MTUS guidelines provide a general recommendation for subacromial decompression. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. The Official Disability Guidelines (ODG) provide more specific indications for subacromial decompression that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Conventional X-rays, AP, and true lateral or axillary view. AND MRI, ultrasound, or arthrogram showing positive evidence of impingement is required. The ODG state that surgery for adhesive capsulitis is under study. The clinical course of this condition is considered self-limiting, and conservative treatment (physical therapy and NSAIDs) is a good long-term treatment regimen for adhesive capsulitis, but there is some evidence to support arthroscopic release of adhesions for cases failing conservative treatment. Guideline criteria have not been met. This patient presents status post right shoulder SLAP repair with recalcitrant adhesive capsulitis. There are clinical exam findings of limited abduction 100 degrees with pain over the biceps tendon and 3/5 weakness. Imaging is reported as unremarkable with no impingement and normal biceps tendon position. There is detailed evidence of extensive physical therapy without progressive improvement, but there is no evidence of a corticosteroid injection in the post-operative period. Therefore, this request is not medically necessary at this time.

Post operative physical therapy for the right shoulder two times a week for three weeks: 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): 26.

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

Associated Surgical Service: assistant surgeon: 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 Centers for Medicare and Medicaid services, Physician Fee Schedule: Assistant Surgeons, <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>.

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