MAXIMUS Federal Services

| Case Number: | CM15-0086029 | | |
|---|---|---|---|
| Date Assigned: | 05/08/2015 | Date of Injury: | 05/27/2014 |
| Decision Date: | 06/30/2015 | UR Denial Date: | 04/17/2015 |
| Priority: | Standard | Application Received: | 05/05/2015 |

## 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 33-year-old male who sustained an industrial injury on 5/27/14, relative to a single vehicle rollover motor vehicle accident. He sustained a right shoulder fracture dislocation and underwent closed reduction. Past medical history was positive for seizures. He underwent right shoulder arthroscopy with subacromial decompression and labral repair on 8/16/14, and subsequent manipulation under anesthesia on 1/24/15. The 2/11/15 agreed medical examiner report stated that more physical therapy was indicated for the right shoulder, injection treatment may be indicated, and further arthroscopic surgery may be needed if he continued to exhibit current levels of range of motion. Right shoulder range of motion was documented as flexion 90, extension 20, abduction 100, adduction 20, external rotation 20, and internal rotation 10 degrees. The 3/17/15 right shoulder MRI impression documented postsurgical changes with fixation of the fractured anterior body of the glenoid to the remainder of the glenoid. There was a tear of the humeral attachment of the inferior glenohumeral ligament, and severe tendinosis of the supraspinatus tendon with attenuation of the tendon and increased signal. There was lateral down sloping of the acromion with mild narrowing of the subacromial space. There was a Hills-Sachs deformity of the tuberosity of the humerus. The 4/7/15 treating physician report cited persistent grade 7/10 pain and stiffness. He continued to have severe stiffness 3 months post manipulation under anesthesia. Imaging demonstrated severe tendinitis and type II acromion with no evidence of labral re-tear. Physical exam documented palpation over the acromioclavicular (AC) joint, greater tuberosity or subacromial space was painless. Shoulder range of motion was documented as flexion 110, extension 50, abduction 90, adduction 50,

internal rotation 30, and external rotation 60 degrees. There was no glenohumeral instability, stress testing of the anterior and posterior capsular structures was negative. Sulcus sign and apprehension test were negative. Motor testing documented 5/5 shoulder strength. The diagnosis was right shoulder adhesive capsulitis with persistent pain, stiffness and weakness. The treatment plan recommended repeat arthroscopy with possible capsular release and debridement of scar tissue consistent with AME recommendations. Authorization was also requested for pain pump for 8 hours, cold therapy unit for 14 days, and sling. The 4/17/15 utilization review non-certified the repeat right shoulder arthroscopy with possible capsular release and debridement of the scar tissue and associated surgical requests as there was no specific pathology identified on imaging that would be addressed by arthroscopy and no objective clinical indications provided. The 5/5/15 treating physician report indicated that the injured worker had failed extensive conservative treatment including therapy, anti-inflammatories, post-operative injections, and manipulation under anesthesia. Physical exam documented right shoulder flexion and abduction 100 degrees with extension, adduction, internal rotation, and external rotation 50 degrees. There was 4-/5 to 4/5 weakness over right shoulder flexors and internal/external rotators. Authorization was again requested for surgery based on the AME recommendations.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Repeat Right Shoulder Arthroscopy with possible capsular release and debridement of the scar tissue:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 195-224. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder (Acute & Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for adhesive capsulitis.

**Decision rationale:** The California MTUS guidelines do not provide surgical recommendations for adhesive capsulitis. The Official Disability Guidelines 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 been met. This injured worker presents with persistent right shoulder pain and stiffness. Clinical exam findings have documented persistent limited range of motion. There is imaging evidence of severe supraspinatus tendinosis and a tear of the humeral attachment of the inferior glenohumeral ligament. Evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary at this time.

**Pain Pump 48 Hours:** 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 Official Disability Guidelines (ODG) Shoulder, Postoperative pain pump.

**Decision rationale:** The California MTUS guidelines are silent regarding this device. The Official Disability Guidelines state that post-operative pain pumps are not recommended. Guidelines state there is insufficient evidence to conclude that direct infusion is as effective as or more effective than conventional pre- or postoperative pain control using oral, intramuscular or intravenous measures. Three recent moderate quality randomized controlled trials did not support the use of pain pumps. Given the absence of guideline support for the use of post-operative pain pumps, this request is not medically necessary.

**Cold Therapy Unit 14 Days:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder (Acute
& Chronic) - Continuous flow cryotherapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Continuous flow cryotherapy.

**Decision rationale:** The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days, including home use. In the postoperative setting, continuous- flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The use of a cold therapy unit would be reasonable for 7 days post-operatively. However, this request for 14 days which is not consistent with guidelines. Therefore, this request is not medically necessary.

**Sling:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder (Acute
& Chronic) - postoperative abduction pillow sling.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 20, 213.

**Decision rationale:** The California MTUS guidelines state that the shoulder joint can be kept at rest in a sling if indicated. Slings are recommended as an option for patients with acromioclavicular separations or severe sprains. Prolonged use of a sling only for symptom control is not recommended. Guideline criteria have been met. The use of a post-operative sling is generally indicated. Therefore, this request is medically necessary.