

Case Number:	CM15-0017610		
Date Assigned:	02/05/2015	Date of Injury:	07/16/2010
Decision Date:	03/25/2015	UR Denial Date:	12/30/2014
Priority:	Standard	Application Received:	01/29/2015

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 57 year old female who sustained an industrial related injury on 7/16/10. The 1/10/13 left shoulder MRI impression documented a Type II-III downsloping acromion with slight beaking, and impingement of the supraspinatus. There was no tear, medial retraction or atrophy. Findings were consistent with biceps tenosynovitis. The 11/11/14 treating physician report cited left shoulder pain, last worst 7-8/10. Range of motion, pushing, pulling, and lifting were significantly painful in the left upper extremity. She also reported left upper extremity weakness. Additional complaints included low back pain radiating down the left leg to the toes, and cervical pain radiating down to the left arm. Left shoulder exam documented painful range of motion with forward flexion 63 degrees, abduction 180 degrees, adduction 50 degrees, external rotation 25 degrees, extension 15 degrees, and internal rotation to the side of the hip. Lumbar spine exam documented positive straight leg raise bilaterally and global left lower extremity weakness. The diagnosis was left shoulder adhesive capsulitis, low back strain, left lower extremity sciatica, and left shoulder sprain. The treatment plan recommended physical therapy for the left shoulder for range of motion and strengthening in order to get range of motion before potential surgery. The treating physician stated the patient had impingement and requested left shoulder subacromial decompression, distal clavicle resection, and possible biceps tenodesis. Range of motion testing was requested for pre-operative assessment. The 12/30/14 utilization review non-certified the request for left shoulder surgery as there was no evidence of conservative treatment. The request for physical therapy was non-certified as there was no documentation of prior therapy or response. The request for range of motion was non-certified as

there was no discussion of why range of motion testing could not be performed utilizing a standard goniometer. The Official Disability Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopic Subacromial Decompression: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-214. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 211. Decision based on Non-MTUS Citation Shoulder: Surgery for impingement syndrome

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery and subacromial decompression. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. The Official Disability Guidelines provide more specific indications for impingement syndrome and acromioplasty 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. Imaging clinical findings showing positive evidence of impingement are required. Guideline criteria have not been met. The patient presents with significant and function-limiting right shoulder pain. Clinical exam documented significant loss of range of motion in flexion, extension, and internal/external rotation. There are imaging findings with positive evidence of impingement. There was no clinical exam documentation relative to strength, tenderness, or impingement testing. There was no documentation of diagnostic or therapeutic injections. Detailed evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is not medically necessary.

ROM Testing: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Neck & Upper Back Chapter Computerized range of motion (ROM)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200. Decision based on Non-MTUS Citation Shoulder: Range of motion Knee and Leg, Computerized muscle testing

Decision rationale: The California MTUS guidelines indicate that shoulder examination should include active and passive range of motion assessment. Routine musculoskeletal evaluation is within the standard evaluation and management services of the treating physician. The Official

Disability Guidelines state that there are no studies to support computerized muscle strength testing of the extremities. The extremities have the advantage of comparison to the other side, and there is no useful application of such a potentially sensitive computerized test. The provider has not established the medical necessity of testing beyond the established parameters of the evaluation and management codes. Guidelines specifically do not support the use of computerized measures when the same testing can be done with manual measurement. Additionally, this was requested for pre-operative evaluation and the associated surgery has found this request not medically necessary.

Pre-op Physical Therapy 2x4 Visits for the left shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Introduction; Physical Medicine Page(s): 9, 98-99. Decision based on Non-MTUS Citation Shoulder: Physical therapy

Decision rationale: The California MTUS guidelines recommend therapies focused on the goal of functional restoration rather than merely the elimination of pain. The physical therapy guidelines state that patients are expected to continue active therapies at home as an extension of treatment and to maintain improvement. The Official Disability Guidelines generally recommend up to 10 visits over 8 weeks for a diagnosis of impingement syndrome, and up to 16 visits over 8 weeks for adhesive capsulitis. Guideline criteria have been met. This patient presents with significant loss of shoulder range of motion and functional ability. There is no evidence in the file of a recent trial of physical therapy or an independent home exercise program. Guidelines support exercise programs in the pre-operative period to increase range of motion and strength. Therefore, this request is medically necessary.