

Case Number:	CM15-0078395		
Date Assigned:	04/30/2015	Date of Injury:	02/25/2012
Decision Date:	06/29/2015	UR Denial Date:	04/09/2015
Priority:	Standard	Application Received:	04/24/2015

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 40-year-old female who sustained an industrial injury on 2/25/12, relative to continuous trauma. The 2/6/15 left shoulder MRI impression documented tendinosis and peritendinitis of the supraspinatus tendon with no rotator cuff tear, and mild arthropathy of the acromioclavicular (AC) joint. Records indicated that conservative treatment had included 3 shoulder injections with temporary benefit. The 3/2/15 treating physician report cited persistent left shoulder pain despite all attempts at aggressive conservative management and the passage of time. Left shoulder exam documented range of motion as flexion 160, extension 40, abduction 160, adduction 80, external rotation 30, and internal rotation 90 degrees. There was severe supraspinatus tenderness, and moderate glenohumeral and AC joint tenderness. There was subacromial crepitus, global 4/5 shoulder strength, and pain with range of motion. AC joint compression test and impingement tests I, II, III were positive. Imaging findings on 2/6/15 revealed AC degenerative joint disease, and tendinosis of the supraspinatus tendon. The diagnosis was left shoulder adhesive capsulitis, impingement syndrome, and AC degenerative joint disease. The treatment plan recommended left shoulder arthroscopic evaluation, subacromial decompression, distal clavicle resection, and manipulation under anesthesia. Authorization was also requested for a home continuous passive motion (CPM) unit for 45 days, Surgi-Stim unit for an initial 90 days, and a Coolcare cold therapy unit. The 4/9/15 utilization review modified the request for left shoulder arthroscopic evaluation, subacromial decompression, distal clavicle resection, and manipulation under anesthesia to left shoulder arthroscopic evaluation, subacromial decompression, and distal clavicle resection. The request

for manipulation under anesthesia was non-certified as range of motion failed to meet guideline criteria that required abduction less than 90 degrees. The request for home continuous passive motion unit was not certified as there was no evidence of adhesive capsulitis. The request for Surgi-Stim unit was non-certified as not supported by guidelines. The request for Coolcare cold therapy unit was modified to 7-day rental of a generic continuous flow cryotherapy unit consistent with guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arthroscopic evaluation, Arthroscopic Sub-Acromial Decompression, Distal Clavicle Resection and Manipulation under Anesthesia, left shoulder: 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 Chapter.

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; Partial claviclectomy; Manipulation under anesthesia.

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. Surgery for impingement syndrome is usually arthroscopic decompression. The Official Disability Guidelines provide more specific indications for impingement syndrome 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, positive impingement sign with a positive diagnostic injection test, and imaging showing positive evidence of impingement. Guideline criteria for partial claviclectomy generally require 6 weeks of directed conservative treatment, subjective and objective clinical findings of acromioclavicular (AC) joint pain, and imaging findings of AC joint post-traumatic changes, severe degenerative joint disease, or AC joint separation. Manipulation under anesthesia is under study as an option for adhesive capsulitis. In cases that are refractory to conservative therapy lasting at least 3-6 months where range-of-motion remains significantly restricted (abduction less than 90), manipulation under anesthesia may be considered. This injured worker presents with persistent left shoulder pain. Clinical exam findings are consistent with imaging evidence of plausible impingement. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. However, there is no clinical evidence of significantly limited range of motion consistent with adhesive capsulitis. The current clinical exam documented abduction of 160 degrees which exceeds the guideline criteria of 90 degrees. The 4/9/15 utilization review partially certified this request to include left shoulder arthroscopic evaluation, subacromial decompression, and distal clavicle resection. There is no compelling reason presented in the available records to support the

medical necessity of manipulation under anesthesia. Therefore, this request is not medically necessary.

Associated surgical service: Home continuous passive motion (CPM) device for initial period of 45 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 Chapter.

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 passive motion (CPM).

Decision rationale: The California MTUS are silent regarding continuous passive motion (CPM) units. The Official Disability Guidelines recommend CPM units for adhesive capsulitis, up to 4 weeks/5 days per week. Guideline criteria have not been met. There is no clinical evidence suggestive of adhesive capsulitis and this request exceeds guideline recommendations. Therefore, this request is not medically necessary.

Associated surgical service: Surgi-stim unit initial period of 90 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 Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: The SurgiStim unit provides a combination of interferential current, neuromuscular electrical stimulation (NMES), and galvanic current. The California MTUS guidelines for transcutaneous electrotherapy do not recommend the use of NMES in the treatment of chronic pain. Galvanic stimulation is considered investigational for all indications. Guidelines suggest that interferential current is not recommended as an isolated intervention. Patient selection criteria is provided if interferential stimulation is to be used despite lack of guideline support and includes ineffective pain control due to diminished effectiveness of medications, intolerance of medications, history of substance abuse, post-operative pain limiting functional ability, and failure to respond to conservative measures. Guideline criteria have not been met. There is no indication that standard post-op pain management would be insufficient. There is no documentation that the patient was intolerant or unresponsive to pain medications during the pre-operative period. If one or more of the individual modalities provided by this multi-modality unit is not supported, then the unit as a whole is not supported. Therefore, this request is not medically necessary.

Associated surgical service: Cool care cold therapy unit: 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 Chapter.

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. The 4/9/15 utilization review decision modified to 7-day rental of a generic continuous flow cryotherapy unit. There is no compelling reason in the records reviewed to support the medical necessity of a cold device beyond the 7-day rental recommended by guidelines and previously certified. Therefore, this request is not medically necessary.