

<b>Case Number:</b>	CM15-0078478		
<b>Date Assigned:</b>	04/29/2015	<b>Date of Injury:</b>	11/09/2012
<b>Decision Date:</b>	05/29/2015	<b>UR Denial Date:</b>	03/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	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 47-year-old male who sustained an industrial injury on 11/09/12. The mechanism of injury was not documented. He underwent right shoulder arthroscopy with subacromial decompression and distal clavicle excision on 11/16/13. The 2/3/15 second opinion orthopedic report cited grade 4/10 right shoulder pain. Pain was better with rest, ice and medication. Pain was worse with reaching and prolonged use. Right shoulder exam documented flexion 120 degrees, abduction 120 degrees, external rotation 80 degrees, and crepitus during range of motion activities. There was diffuse right shoulder tenderness and 5/5 supraspinatus and external rotation strength. Upper extremity neurologic exam was within normal limits. He underwent an intraarticular and subacromial corticosteroid injections with temporary relief of symptoms. The treatment plan recommended revision right shoulder surgery including lysis of adhesions, debridement and manipulation under anesthesia. The diagnosis was right shoulder impingement syndrome, status post right shoulder arthroscopic subacromial decompression, and post-operative right shoulder adhesive capsulitis. The 3/6/15 treating physician report cited right shoulder discomfort particularly with overhead activity. He had injections in the shoulder and physical therapy without long-term relief of his symptoms. Physical exam documented shoulder range of motion as 140 degrees forward elevation and abduction with early firm end-point, and limitation in internal/external rotation. The shoulder was limited particularly in internal rotation. Strength was fairly normal. The treatment plan recommended arthroscopy with decompression of subacromial space with partial acromioplasty. The 3/25/15 utilization review non-certified the request for right shoulder arthroscopy with partial acromioplasty, lysis of adhesions, and

manipulation as the documented range of motion exceeded guideline criteria for manipulation. The 4/20/15 injured worker appeal letter documented the history of post-op treatment following the October 2013 right shoulder surgery. There was continued right shoulder pain and difficulty with activities of daily living. The injured worker reported muscular resistance and popping during movement and temporary relief with corticosteroid injection. He stated that his surgeon and a second opinion consult were in agreement on the medical necessity of the requested surgery.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Right shoulder arthroscopy with partial acromioplasty, lysis of adhesions and manipulation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), 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 adhesive capsulitis, Acromioplasty; Surgery for impingement syndrome; Manipulation under anesthesia (MUA).

**Decision rationale:** The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. The Official Disability Guidelines for acromioplasty require 3 to 6 months of conservative treatment plus weak or absent abduction and positive impingement sign with a positive diagnostic injection test. There should be imaging evidence showing positive evidence of impingement. Guidelines state that surgery for adhesive capsulitis is under study, but there is some evidence to support arthroscopic release of adhesions for cases failing conservative treatment. Manipulation under anesthesia is under study as an option for adhesive capsulitis. In cases that are refractory to conservative therapies lasting at least 3-6 months where range-of-motion remains significantly restricted (abduction less than 90), manipulation under anesthesia may be considered. Guideline criteria have not been met. This injured worker presents with persistent right shoulder pain that is functionally limiting. Clinical exam evidence documented abduction range of motion of 120-140 degrees, in excess of guideline recommendations for manipulation under anesthesia. There is no clinical exam evidence of a positive impingement test or shoulder weakness to support acromioplasty. Additionally, there is no post-operative imaging studies documented in the submitted records to show positive evidence of impingement. Therefore, this request is not medically necessary.

**Associated surgical services: Shoulder brace, cold compression, and continuous passive motion machine for three weeks' rental:** 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): 205, 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Cold compression therapy; continuous passive motion (CPM); Postoperative abduction pillow sling.

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

**Associated surgical services: Physical therapy, once for one week, then three times weekly for four 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.