

<b>Case Number:</b>	CM15-0098318		
<b>Date Assigned:</b>	05/29/2015	<b>Date of Injury:</b>	03/14/2013
<b>Decision Date:</b>	08/24/2015	<b>UR Denial Date:</b>	04/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/21/2015

### 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: California  
 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 48 year old female, who sustained an industrial injury on 03/14/2013. She was reported that she was unable to move her right arm. She was diagnosed with a frozen shoulder. Treatment to date has included x-rays, medications, MRI, physical therapy for the right and left shoulder, cortisone injections to the left and right shoulder, right shoulder surgeries, MRI arthrogram and acupuncture. According to a progress report dated 03/26/2015, the injured worker had persistent pain and stiffness in the right shoulder and persistent pain in the left shoulder. Shoulder forward flexion is noted to be 145 degrees with external rotation of 70 degrees. The injured worker was having significant stress and anxiety and appeared outwardly depressed. MRI of the left shoulder performed on 02/04/2015 showed minimal to mild acromioclavicular arthrosis, tendinosis of the supraspinatus with minimal calcific deposit. MRI of the right shoulder with intraarticular contrast performed on 12/24/2013 showed very low grade partial tearing of the supraspinatus. There may be calcium deposit at the footplate of the supraspinatus. There was interval development of a low signal in the distal subscapularis tendon which could represent calcium hydroxyapatite deposition versus air bubble. There was mild tenosynovitis of the biceps tendon. There were changes consistent with subacromial decompression. Diagnoses included status post right shoulder arthroscopy, arthroscopic subacromial decompression, status post manipulation under anesthesia right shoulder, residual adhesive capsulitis/impingement syndrome right shoulder and impingement syndrome left shoulder. Treatment plan included right shoulder surgery. The provider noted that the injured worker was exhibiting signs of secondary stress, anxiety and depression. It appeared to be

related to chronic pain and disability. Recommendations included a psychiatric consultation and treatment if indicated. The injured worker was having severe pain and was placed on temporary total disability. Currently under review is the request for right shoulder arthroscopy, lysis of adhesions, possible subacromial decompression/acromioplasty and manipulation under anesthesia and associated services included postoperative physical therapy, preoperative medical clearance, cold therapy device, Ultra Sling and CPM.

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

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

**Right shoulder arthroscopy, lysis of adhesions, possible subacromial decompression/acromioplasty and manipulation under anesthesia: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**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:** CA MTUS/ACOEM Guidelines are silent on the issue of surgery for adhesive capsulitis. According to the ODG Shoulder section, surgery for adhesive capsulitis, 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. The guidelines recommend an attempt of 3-6 months of conservative therapy prior to contemplation of manipulation and when range of motion remains restricted (abduction less than 90 degrees). In this case there is insufficient evidence of failure of conservative management in the notes submitted from 3/26/15 or clear evidence of adhesive capsulitis as the patient has forward flexion of a 145 degrees. Therefore, the determination is for not medically necessary.

**Associated service: Postoperative physical therapy; eighteen (18) sessions (3 times 6): Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated service: Preoperative medical clearance: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated service: Cold therapy device:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated service: Ultrasling:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated service: CPM. three (3) weeks:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.