

<b>Case Number:</b>	CM14-0072718		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	10/30/2013
<b>Decision Date:</b>	08/25/2015	<b>UR Denial Date:</b>	04/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/20/2014

### 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:

This injured worker is a 52-year-old male who sustained an industrial injury on 10/30/13. Injury occurred when he was rolling a tape tool with onset of shoulder pain. Initial conservative treatment included physical therapy and activity modification. The 11/3/13 left shoulder x-rays documented arthritic changes of the acromioclavicular (AC) joint. The 1/3/14 left shoulder MRI impression documented no conclusive evidence of acute internal derangement within the shoulder. The rotator cuff muscles and associated tendons appeared morphologically intact. A Type II acromion process was observed without conclusive evidence of subacromial impingement. The 1/8/14 treating physician report cited persistent constant grade 6/10 left shoulder pain with associated symptoms of catching, grinding, locking, popping, stiffness, swelling and weakness. Symptoms were aggravated by activities of daily living, repetitive activities, overhead activities and reaching behind his back. Physical exam documented moderate tenderness at the coracoid process and pectoralis. Left shoulder range of motion testing documented passive abduction 90 degrees, passive flexion 135 degrees, and passive external rotation with the arm at the side 30 degrees. Neer's impingement sign was mildly positive. Shoulder strength was normal. Imaging was reviewed and show moderate hypertrophy of the AC joint with decreased joint space inferiorly and no significant mass effect. There was some increased fluid in the subcutaneous tissue above the AC joint. There was mild supraspinatus tendinosis with a small subchondral cyst noted in the greater tuberosity adjacent to the articular surface attachment of the supraspinatus. He had completed 11/12 physical therapy session with progress in strength but quite significant pain. He was diagnosed with a frozen shoulder. He

underwent left shoulder manipulation under anesthesia on 2/13/14 and attended physical therapy. The 4/10/14 treating physician report indicated the injured worker had completed physical therapy with better motion but continued significant pain in reaching overhead and outward. Left shoulder exam documented no tenderness, mild crepitation at the subacromial space, and positive Neer's, Hawkins' and cross body AC compression tests. Passive left shoulder range of motion was 80 degrees abduction, 120 degrees flexion, and 30 degrees external rotation. The diagnosis was left shoulder pain, adhesive capsulitis, subacromial impingement syndrome, and AC joint osteoarthritis. Imaging showed no rotator cuff or biceps tendon tear. There was some moderate AC joint hypertrophy. He continued to have pain not significantly altered by manipulation under anesthesia or physical therapy. Authorization was request for shoulder surgery, arthroscopy, subacromial decompression, distal claviclectomy including distal articular. The 4/18/14 utilization review non-certified the request for shoulder arthroscopic surgery as the request was for correction of adhesive capsulitis without any radiographic or special imaging findings of internal derangement to support the medical necessity of surgery. Guidelines do not support arthroscopic procedures as more effective than manipulation under anesthesia. The 6/11/14 orthopedic report cited persistent left shoulder pain with forward flexion 90, abduction 90, external rotation 30, and internal rotation to L5. X-rays were taken and documented as normal. MRI was reviewed and showed only adhesive capsulitis. A repeat MRI was requested.

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

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

**Shoulder surgery arthroscopy, subacromial decompression, distal claviclectomy including distal articular:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

**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; Surgery for rotator cuff repair, Partial claviclectomy.

**Decision rationale:** The California MTUS guidelines provide a general recommendation for impingement surgery and rotator cuff 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 and partial thickness rotator cuff repairs 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 or rotator cuff deficiency. 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. Guideline criteria have not been met. This injured worker

presents with persistent left shoulder pain with limited range of motion. He was diagnosed with adhesive capsulitis and underwent manipulation under anesthesia 2 months prior to this request with some short term improvement in range of motion but no reduction in pain. Clinical exam findings did not document tenderness over the rotator cuff or anterior acromial area, and there was no evidence of a possible diagnostic injection test. Imaging and x-ray findings did not show evidence of possible impingement or a rotator cuff deficit. Detailed evidence of at least 3 months a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure had not been submitted. Additional diagnostic testing was noted to be pending. Therefore, this request is not medically necessary at this time.