

Case Number:	CM14-0079159		
Date Assigned:	09/22/2014	Date of Injury:	01/18/2001
Decision Date:	09/29/2015	UR Denial Date:	05/17/2014
Priority:	Standard	Application Received:	05/29/2014

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 55-year-old female who sustained an industrial injury on 1/18/01. Injury occurred relative to a motor vehicle accident. Surgical history included C5/6 anterior cervical discectomy and fusion on 3/20/06, L4-S1 lumbar fusion on 5/10/10, L4-S1 anterior fusion on 6/23/10, and additional lumbar surgeries in 2011 for incision and drainage. She underwent right shoulder rotator cuff repair in 2003, and right shoulder arthroscopic acromioplasty and rotator cuff repair on 3/19/13. She underwent post-op physical therapy, including aquatic therapy. The 3/12/14 right shoulder MRI impression documented cystic remodeling of the greater tuberosity in proximity to very small articular surface tear defect involving the critical zone of the conjoined portion of the cuff. The tear is well less than 60% thickness of the cuff. There was an interval cuff repair with suture anchors. The acromioclavicular (AC) joint was degenerated with some mass effect on the underlying cuff and this may contribute to impingement. It was noted that a subacromial decompression had been performed. There was glenohumeral capsulitis. The 4/14/14 treating physician report cited persistent right shoulder pain with loss of range of motion. Physical exam documented mild shoulder atrophy with minimal crepitus. Range of motion was documented as flexion 120 degrees. External rotation was 20 degrees with the elbow to the side and in 90 degrees of abduction. She could externally rotate 60 degrees and internally rotate to the greater trochanter. There was 5/5 external rotation strength. Infraspinatus lag test was 5/5 and belly test was negative. She was unable to perform lift off test. Impingement signs 1, 2, and 3 were mildly positive. Imaging showed a low-grade partial thickness supraspinatus tendon tear and glenohumeral capsulitis. She had on-going loss of motion and pain with objective evidence of adhesive capsulitis. Authorization was requested for right shoulder arthroscopic extensive debridement and possible capsular release, pre-operative medical clearance, 12 post-operative

physical therapy sessions, and pre-operative EKG and labs. The 5/17/14 utilization review non-certified the right shoulder arthroscopic extensive debridement and possible capsular release and associated surgical requests as there was no documentation of a positive injection test.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Right shoulder arthroscopic extensive debridement as well as possible capsular release: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210. Decision based on Non-MTUS Citation (ODG), Indications for Surgery, Rotator cuff repair.

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; Surgery for Impingement syndrome; Surgery for rotator cuff repair.

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. The Official Disability Guidelines (ODG) 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. The ODG state that surgery for adhesive capsulitis is 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. Guideline criteria have not been fully met. This injured worker presented with persistent right shoulder pain and loss of range of motion. She was status post two right shoulder rotator cuff repairs and acromioplasty, most recently on 3/19/13, followed by post-op physical therapy. Clinical exam findings were consistent with imaging evidence of partial thickness rotator cuff tear, AC joint degeneration with plausible impingement, and glenohumeral capsulitis. There is no documentation of a positive diagnosis injection test. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial relative to the right shoulder and failure has not been submitted. Therefore, this request is not medically necessary.

1 Pre-operative medical clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation General surgery information and ground rules, California Official Medical Fee Schedule, 1999 Edition, pages 92-93.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun.

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

12 Post-operative physical therapy sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

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

1 Pre-operative EKG: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116 (3): 522-38.

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

Pre-operative Labs: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116 (3): 522-38.

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