

Case Number:	CM13-0009736		
Date Assigned:	09/18/2013	Date of Injury:	04/26/2011
Decision Date:	02/03/2014	UR Denial Date:	07/09/2013
Priority:	Standard	Application Received:	08/12/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 claimant is a 61-year-old gentleman who sustained an injury to his right shoulder in a work related accident on April 26, 2011. It was noted that following a course of conservative care, that the claimant ultimately underwent a right shoulder rotator cuff repair, biceps tenodesis, distal clavicle resection and arthroscopic subacromial decompression in June of 2012. Postoperatively, he was treated with an aggressive course of formal physical therapy, but developed a diagnosis of "adhesive capsulitis". Recent clinical assessments for review include a June 20, 2013 progress report by treating physician [REDACTED] indicating the claimant was with continued subjective complaints of shoulder pain with restricted motion despite conservative care with formal physical examination findings showing 120 degrees of flexion, external rotation to 30 degrees and tenderness to palpation both anteriorly and laterally. Further findings were not noted. The claimant was diagnosed with postoperative right shoulder adhesive capsulitis and based on continued symptoms, recommendations were for a shoulder manipulation under anesthesia with an arthroscopic capsular release as well as role of postoperative physical therapy, a ThermoCool Unit and seven day use of a Continuous Passive Motion (CPM) device.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder Manipulation vs. Arthroscopy Capsular Release: 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 -Manipulation under anesthesia (MUA)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ACOEM), 2nd Edition, (2004) pg. 209-212, Shoulder, Surgical Considerations. Additionally, Official Disability Guidelines (ODG)-- Official Disability Guidelines Treatment in Worker's Comp , 18th Edition, 2013 Updates: Shoulder Procedure - Manipulation under anessthe

Decision rationale: California MTUS Guidelines do not specifically address this request however when looking at Official Disability Guideline criteria, manipulation under anesthesia is only indicated for the shoulder if documentation of continued lack of motion with less than 90 degrees of abduction and six months of conservative care is noted. The claimant's course of conservative care, while noted to be with physical therapy, fails to demonstrate recent attempts at treatment to necessitate the requested process. Furthermore, in this case the claimant's last physical examination showed 120 degrees of flexion with no documentation of abduction less than 90 degrees. This in and of itself would not support the role of a manipulation under anesthesia. Finally, clinical Guidelines do not support the role of any form of arthroscopic intervention for a diagnosis of adhesive capsulitis. The requested role of a capsular release in the clinical setting of this claimant would not be indicated. Finally, in this case it should be taken into account that no postoperative imaging is available for review to assess the claimant's rotator cuff that was fixed surgically. Absence of clinical imaging also would not support the role of the surgical process in question.

Right Shoulder Post-OP PHYSICAL THERAPY (PT) x 24 sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines, Postsurgical Treatment Guidelines.

Decision rationale: Based on California MTUS Postsurgical Rehabilitative Guidelines, twenty-four sessions of physical therapy would not be indicated. The recommendations in this case have not supported the need of the operative procedure in question. This would negate the need for this postoperative physical therapy request

Thermocool 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 (ODG), Shoulder - Continuous-flow cryotherapy

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, shoulder procedure - Continuous-flow cryotherapy.

Decision rationale: The Physician Reviewer's decision rationale: California MTUS Guidelines are silent. When looking at Official Disability Guideline criteria, a cryotherapy device would be indicated for seven days including home use in the postoperative setting. However, the role of surgical process in this case has not been supported. This would negate the need for the role of a ThermoCool device.

7-Day Rental Continuous Passive Motion 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 (ODG). Shoulder - Continuous- Continuous passive motion (CPM).

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Worker's Comp. shoulder procedure - Continuous passive motion (CPM)

Decision rationale: MTUS Guidelines are silent. When looking at Official Disability Guideline criteria, a seven day rental of a CPM unit would not be indicated. CPM Is not supported by Official Disability Guideline criteria for use in the shoulder. There is nothing indicating this claimant being an exception to that rule. Furthermore, the need for operative intervention and manipulation under anesthesia procedure has not been supported. The role of this postoperative device would not be indicated.