

<b>Case Number:</b>	CM13-0043766		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	06/29/2009
<b>Decision Date:</b>	08/15/2014	<b>UR Denial Date:</b>	10/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/31/2013

### 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. The expert 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 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/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:

This 54-year-old female office services assistant sustained an industrial injury on 6/29/09, relative to a slip and fall. The patient underwent right shoulder arthroscopy with rotator cuff repair, subacromial decompression, and distal clavicle resection on 1/31/13. The patient completed post-operative physical therapy consistent with post-surgical treatment guidelines. The 9/13/13 right shoulder MRI impression documented mild supraspinatus tendinitis with mild distal anterior interstitial fraying, mild subscapularis tendinosis, and os acromiale. There was mild lateral downsloping of the acromion with very mild distal osseous spurring which mildly increased the anatomic risk for rotator cuff impingement. There was mild scarring within the rotator cuff interval, sometimes associated with chronic adhesive capsulitis. The 9/16/13 progress report cited grade 7/10 right shoulder pain and reduced range of motion. Right shoulder exam findings documented tenderness to palpation over the anterior and lateral shoulder. Range of motion testing documented flexion 90, extension 20, abduction 90, internal rotation 10, and external rotation 75 degrees. The diagnosis was adhesive capsulitis. The 9/27/13 progress report cited persistent right shoulder pain with limited range of motion and functional activity. Physical exam documented passive forward flexion to 160 degrees with guarding and moderate pain. The patient was able to externally rotate to 80 degrees and internally rotate to the lower lumbar spine. There is 4+/5 rotator cuff weakness with mild to moderate pain. The impression documented persistent right shoulder pain and stiffness with adhesive capsulitis. Manipulation under anesthesia with cortisone injection was recommended, followed by aggressive physical therapy. The 10/16/13 utilization review certified a request for right shoulder cortisone injection and denied the request for right shoulder manipulation and associated physical therapy as clinical findings of range of motion did not meet guideline criteria.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Right Shoulder 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, Manipulation under anesthesia.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Manipulation under anesthesia (MUA).

**Decision rationale:** The California MTUS does not provide specific criteria for shoulder manipulation. The Official Disability Guidelines state that manipulation under anesthesia is under study as an option for adhesive capsulitis. In cases that are refractory to conservative therapy lasting at least 3-6 months where range-of-motion remains significantly restricted (abduction less than 90), manipulation under anesthesia may be considered. The use of physical therapy and injections are recommended for the treatment of adhesive capsulitis. Guideline criteria have not been met. Clinical findings of passive forward flexion to 160 degrees do not support the diagnosis of adhesive capsulitis. There is muscle guarding and significant limitation in active range of motion noted. Guidelines would support additional conservative treatment. Therefore, this request for right shoulder manipulation is not medically necessary.

### **Post-Operative Daily Physical Therapy For 2 Weeks for a Total of 14 Visits: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

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

### **After Daily Then Physical Therapy 3 Times a Week For 2 Weeks for a Total of 6 Visits: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

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

### **Then Physical Therapy 2 Times a Week for 2 Weeks: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s):  
26.

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