

<b>Case Number:</b>	CM14-0014268		
<b>Date Assigned:</b>	03/14/2014	<b>Date of Injury:</b>	12/02/1999
<b>Decision Date:</b>	08/07/2014	<b>UR Denial Date:</b>	01/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/04/2014

### 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. The expert reviewer is Board Certified in Occupational Medicine 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:

Patient is a 64-year-old male who has submitted a claim for chronic left lateral elbow tendinosis, left shoulder adhesive capsulitis, and left shoulder pain with probable subacromial bursitis associated with an industrial injury date of 12/02/1999. Medical records from 2013 were reviewed. Patient complained of left shoulder pain and stiffness aggravated upon lifting objects. Range of motion of the left shoulder was 120 degrees upon forward elevation actively and 150 degrees passively, and 50 degrees upon external rotation. Range of motion was painful at extreme range. Left supraspinatus insertion region was tender. A progress report from 08/12/2013 cited that left shoulder manipulation will not be able to improve his range of motion any further; hence, a corticosteroid injection was performed instead. The steroid injection provided him three weeks of pain relief. A repeat injection was performed on 11/06/2013. X-rays of the left shoulder, showed nice decompression with a flat acromion, no abnormal calcifications, and a good acromiohumeral space. The official report was not made available for review. Treatment to date has included left shoulder manipulation under anesthesia on 03/10/2014, left shoulder corticosteroid injections x 3 on 08/12/2013, 11/06/2013, and 01/29/2014; home exercise program, and medications such as Oxycodone, Celebrex, Voltaren, and Ambien. The utilization review from 01/17/2014 denied the requests for left shoulder manipulation and steroid injection because the outcomes from the corticosteroid injection were not documented; and denied physical therapy, left shoulder because the requested procedure had been deemed not medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **LEFT 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 (ODG).

**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 Section, Manipulation under Anesthesia.

**Decision rationale:** Surgical intervention is indicated for patients who have: red flag conditions; activity limitation for more than four months, plus existence of a surgical lesion; and failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs. ODG criteria for manipulation under anesthesia include adhesive capsulitis refractory to conservative therapy lasting at least 3-6 months where abduction remains less than 90 degrees. Manipulation under anesthesia (MUA) for frozen shoulder may be an effective way of shortening the course of this disease and should be considered when conservative treatment has failed. In this case, there was no documented rationale given for this procedure. There was no evidence that the patient was subjected to physical therapy, and subsequently failed warranting this procedure. Moreover, recent progress reports failed to provide data on left shoulder range of motion towards abduction. Due to insufficient information, the request is not medically necessary.

## **CORTICOSTEROID INJECTION: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Section, Steroid Injection.

**Decision rationale:** Steroid injection for adhesive capsulitis when combined with a simple home exercise program is effective in improving shoulder pain and disability in patients. Adding supervised physical therapy provides faster improvement in shoulder range of motion. Up to three injections were beneficial, with limited evidence that four to six injections were beneficial. In this case, the patient has known left adhesive capsulitis. Treatments received were medications and corticosteroid injections given on 08/12/2013 and 11/06/2013, which provided three weeks of pain relief. However, there was no evidence that the patient was subjected to physical therapy, a necessary adjunct for steroid injection. The request likewise failed to specify laterality and body part to be treated. Guideline criteria were not met. Due to insufficient information, the request is not medically necessary.

## **24 PHYSICAL THERAPY SESSIONS FOR THE LEFT SHOULDER: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Section, Physical Therapy.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines state that physical medicine is recommended and that given frequency should be tapered and transitioned into a self-directed home program. ODG recommends 16 visits of physical therapy over 8 weeks for adhesive capsulitis. In this case, the patient has known adhesive capsulitis. It is not clear if he was subjected to physical therapy in the past due to insufficient documentation. Moreover, the request exceeded guideline recommendations of 16 visits. As such, the request is not medically necessary.