

<b>Case Number:</b>	CM14-0022380		
<b>Date Assigned:</b>	03/05/2014	<b>Date of Injury:</b>	10/24/2012
<b>Decision Date:</b>	05/20/2014	<b>UR Denial Date:</b>	02/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/22/2014

### 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 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:

The claimant is a 51-year-old female who sustained an injury to the left shoulder on October 24, 2012. The clinical records provided for review include a February 5, 2013 progress report indicating continued complaints of pain in the left shoulder with physical examination of 5/5 motor strength, limited active range of motion and anterior tenderness to palpation. Specific motion parameters were not given. The recommendation was made to continue nonsteroidal medication and for surgical arthroscopy, subacromial decompression and manipulation under anesthesia for the diagnosis of left shoulder impingement. A report of an MRI dated November 17, 2013 showed rotator cuff tendinosis with a glenohumeral joint effusion and moderate degenerative changes in the AC joint. Documentation indicated that conservative care has included medication usage, work restrictions, physical therapy, and activity restrictions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION OF SUBACROMIAL SPACE WITH PARTIAL ACROMIOPLASTY:** 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 Chapter.

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

**Decision rationale:** Based on California ACOEM Guidelines, surgical arthroscopy with decompression would not be indicated. The clinical records provided for review do not demonstrate weakness on examination. There is also no documentation that the claimant received a prior injection for the shoulder. ACOEM Guidelines recommend surgical arthroscopy and decompression after failing three to six months of conservative measures including injection therapy. The absence of the above would fail to support the surgery as medically necessary and appropriate.

**MANIPULATION UNDER ANESTHESIA, SHOULDER JOINT, INCLUDING APPLICATION OF FIXATION APPARATUS:** 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:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th edition, 2013 Updates: shoulder procedure - Manipulation under anesthesia (MUA).

**Decision rationale:** The CA MTUS and ACOEM Guidelines do not address manipulation under anesthesia. When looking at Official Disability Guidelines, the request for manipulation under anesthesia cannot be recommended as medically necessary. The records provided for review indicate only that the claimant has limited active range of motion. There is no documentation of the specific numerical values for the restricted range of motion or that the claimant's motion is less than 90 degrees of active abduction that would support the need for the surgical procedure. When taking into account the lack of documentation of recent conservative care including injection therapy, and the lack of documented range of motion, the need for this portion of shoulder procedure would not be indicated.

**CLAVICULECTOMY; PARTIAL - CLAVILECTOMY+PARTIAL:** 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:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th edition, 2013 Updates: shoulder procedure - Partial claviclectomy (Mumford procedure).

**Decision rationale:** The CA MTUS and ACOEM Guidelines do not address this request. When looking at Official Disability Guideline criteria, distal clavicle excision cannot be recommended as medically necessary. The need for operative intervention in this case has not been established,

thus negating this specific portion of the surgical process. Claviclectomy; Partial - Claviclectomy+Partial is not medically necessary and appropriate.

**CAPSULAR CONTRACTURE 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).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th edition, 2013 Updates: shoulder procedure - Surgery for adhesive capsulitis.

**Decision rationale:** The CA MTUS and ACOEM Guidelines do not address this request. When looking at Official Disability Guideline criteria, the role of capsular contracture release also would not be indicated. The need for operative intervention in this case has not been established thus negating this specific portion of the surgical process in question. The Capsular Contracture Release is not medically necessary and appropriate.

**EIGHT (8) SESSIONS OF POST-OP PHYSICAL THERAPY: 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 Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation MTUS: POST-SURGICAL TREATMENT GUIDELINES, CA MTUS 2009 POST SURGICAL REHABILITATION: ROTATOR CUFF SYNDROME/IMPINGEMENT SYNDROME (ICD9 726.1; 726.12);

**Decision rationale:** The proposed surgical procedure cannot be recommended as medically necessary for this claimant. Therefore, the request for eight sessions of postoperative physical therapy is not necessary.

**CTU PURCHASE/RENTAL - SEVEN (7) DAYS: 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:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure - Continuous-flow cryotherapy.

**Decision rationale:** The proposed surgical procedure cannot be recommended as medically necessary for this claimant. Therefore, the request for purchase/rental of a cryotherapy unit is not necessary.

**PRE-OP CLEARANCE:** 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:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7 INDEPENDENT MEDICAL EXAMINATIONS AND CONSULTATIONS, 127

**Decision rationale:** The proposed surgical procedure cannot be recommended as medically necessary for this claimant. Therefore, the request for preoperative medical clearance is not necessary.