

Case Number:	CM14-0042867		
Date Assigned:	06/30/2014	Date of Injury:	10/29/2012
Decision Date:	08/21/2014	UR Denial Date:	03/13/2014
Priority:	Standard	Application Received:	04/10/2014

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 Orthopaedic 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 49-year-old female sustained an industrial injury on 10/29/12. The mechanism of injury was not documented. The patient underwent left shoulder arthroscopy with subacromial decompression, acromioclavicular (AC) joint resection, and debridement partial labral tear on 5/2/13. The 2/12/14 treating physician report indicated that the patient had improved approximately 60% after left shoulder surgery but had plateaued. She had not yet been scheduled for physical therapy. Left shoulder exam documented tenderness over the greater tuberosity and 4/5 resisted abduction and external rotation strength. Left shoulder range of motion testing documented abduction 90, forward flexion 90, and external rotation 20 degrees. Thoracolumbar exam documented normal gait, no tenderness or spasms, normal strength and reflexes, negative nerve tension signs, and normal range of motion with pain in full flexion. The diagnosis was frozen left shoulder, rule-out rotator cuff tear, and thoracolumbar strain. The treatment plan requested authorization for left shoulder manipulation under anesthesia, Diclofenac XR 100 mg #60, omeprazole 20 mg #60 to reduce gastritis from non-steroidal anti-inflammatory drugs, prophylaxis 30 tabs, and tramadol ER 150 mg #30. The 3/13/14 utilization review denied the request for left shoulder manipulation under anesthesia, physical therapy, prophylaxis #30, and tramadol #30. The requests for Diclofenac #60 and omeprazole #60 were certified. The rationale for the utilization review decision was not available for review. The undated appeal letter stated that the patient had a frozen left shoulder status post surgery on 5/2/13 and was a candidate for manipulation under anesthesia to relieve the continued significant pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Manipulation under anesthesia of the left shoulder.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Management Guidelines.

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

Decision rationale: The California MTUS does not provide recommendations for manipulation under anesthesia (MUA). The Official Disability Guidelines state that MUA is under study as an option in 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. Guideline criteria have not been met. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried and failed. The 2/12/14 progress report indicates that physical therapy had not yet been scheduled. The appeal stated that MUA was to relieve continued significant pain, which is not a guideline indication. Therefore, this request for manipulation under anesthesia of the left shoulder is not medically necessary.

Physical therapy three visits per week for six weeks to the lumbar and sacral vertebrae and left shoulder.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Management 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, Physical therapy.

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) Post-Surgical Treatment Guidelines do not apply to this case as the 6-month post-surgical treatment period had expired and manipulation under anesthesia is not medically necessary. Chronic Pain Medical Treatment Guidelines would apply. The MTUS guidelines recommend therapies focused on the goal of functional restoration rather than merely the elimination of pain. For a diagnosis of myalgia/myositis, physical therapy is recommended for 9-10 visits. Official Disability Guidelines would support physical therapy for the shoulder up to 16 visits. In general, a trial of physical therapy to assess functional benefit is generally recommended for 6 visits. Guideline criteria have not been met. There is no functional deficit documented relative to the low back to support the medical necessity of physical therapy. A trial of 6 visits of physical therapy to assess whether functional gains in range of motion can be achieved is consistent with guidelines for the diagnosis of frozen shoulder. Records suggest that therapy has been certified but not scheduled. There are no findings to support the medical necessity of physical therapy to the lumbosacral region. Therefore, this request for physical therapy three visits per week for six weeks to the lumbar and sacral vertebrae and left shoulder is not medically necessary.

Prophyaxie #30.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Management Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: This request for prophylaxis #30 is not specified but appears to relate to omeprazole which was prescribed for gastritis induced by non-steroidal anti-inflammatory drugs. The recommended daily adult oral dose for omeprazole is 20 mg once daily. The patient has been prescribed omeprazole 20 mg #60 tabs with follow-up in one month. There is no compelling reason to supply an additional #30 tablets. Therefore, this request for prophylaxis #30 is not medically necessary.