

<b>Case Number:</b>	CM15-0186417		
<b>Date Assigned:</b>	09/28/2015	<b>Date of Injury:</b>	05/22/2014
<b>Decision Date:</b>	12/02/2015	<b>UR Denial Date:</b>	08/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/22/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 injured worker is a 53-year-old male who sustained an industrial injury on 5/22/14. Injury occurred when he was using a backhoe and his right arm and leg got caught in the bucket, lifting him approximately 8 feet off the ground before he fell to the ground. He was diagnosed with bilateral rib fractures, possible left clavicle fracture, and right femoral trochanter fracture. He underwent left shoulder arthroscopic subacromial decompression, distal clavicle resection, and posterior rotator cuff repair on 11/26/14. The injured worker underwent a left shoulder subacromial corticosteroid injection on 4/21/15 and was prescribed 3 weeks of additional physical therapy. The 6/2/15 treating physician report cited chronic recurrent left shoulder soreness and weakness most noticeable when attempting to reach or perform lifting activities. Imaging showed significant attenuation of the previously repaired supraspinatus tendon with similar attenuation of the subscapularis and infraspinatus tendon insertions. Orthopedic referral was recommended to a shoulder specialist. The 8/6/15 orthopedic report cited constant grade 6/10 left shoulder pain despite surgery and post-operative physical therapy. Left shoulder exam documented well-healed incisions, no signs/symptoms of infection, and limited rotator cuff strength testing due to pain but weakness was appreciated. Active range of motion was forward flexion 90 degrees, abduction 90 degrees, and external rotation 15 degrees. Imaging of the left shoulder documented a recurrent rotator cuff tear with retraction and atrophy. The orthopedic surgeon opined that the recurrent rotator cuff tear with retraction was irreparable. The treatment plan recommended manipulation under anesthesia with an intra-articular injection to try to regain his range of motion. In the future, he would be a candidate for hemiarthroplasty or reverse total

shoulder arthroplasty. Authorization was requested for left shoulder manipulation under anesthesia, left shoulder corticosteroid injection, 10 visits of post-injection physical therapy for the left shoulder, CPM (continuous passive motion) machine, and cold therapy unit. The 8/28/15 utilization review non-certified the left shoulder manipulation under anesthesia and associated requests as there was no detailed evidence of conservative treatment in the last 3 months.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Manipulation under Anesthesia, Left Shoulder QTY: 1: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Online Version, Manipulation under Anesthesia (MUA).

**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 guidelines do not provide surgical criteria for manipulation under anesthesia. The Official Disability Guidelines stated 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. Guideline criteria have been met. This injured worker presents with an irreparable recurrent rotator cuff tear with retraction and atrophy. Clinical exam findings are consistent with adhesive capsulitis. Detailed evidence of up to 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, including physical therapy and corticosteroid injection, and failure has been submitted. Therefore, this request is medically necessary.

#### **Corticosteroid Injection, Left Shoulder QTY: 1: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Summary. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Steroid injections.

**Decision rationale:** The California MTUS recommend two or three subacromial cortisone injections over an extended period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome, or small tears. The Official Disability Guidelines recommend steroid injections for the shoulder when indications are met. Indicated diagnoses include adhesive capsulitis, impingement syndrome, or rotator cuff problems. Criteria include pain not adequately controlled by conservative treatments, pain interferes with functional activities, intended for short term control of symptoms to resume conservative medical management. Guideline criteria have been met. This injured worker has been recommended for

left shoulder manipulation under anesthesia in the setting of an irreparable recurrent rotator cuff tear with retraction and atrophy. Clinical exam findings are consistent with adhesive capsulitis. Conservative treatment failure has been documented. The use of an intra-operative corticosteroid injection for short term control of symptoms to resume conservative medical management, such as physical therapy, would be consistent with guidelines. Therefore, this request is medically necessary.

**Post-Injection Physical Therapy, Once Weekly, Left Shoulder QTY: 10: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Online Version, Physical Therapy.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment 2009, Section(s): Shoulder.

**Decision rationale:** The California Post-Surgical Treatment Guidelines for surgical treatment of adhesive capsulitis suggest a general course of 24 post-operative physical medicine visits over 14 weeks, during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 12 visits. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical period. This is the initial request for post-operative physical therapy and consistent with guideline recommendations. Therefore, this request is medically necessary.

**CPM Machine, Left Shoulder QTY: 1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Online Version, Continuous passive motion (CPM).

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

**Decision rationale:** The California MTUS does not provide recommendations for continuous passive motion (CPM) following shoulder surgery. The Official Disability Guidelines state that CPM is recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. Guideline criteria have been met for the use of a post-operative continuous passive motion device for up to 4 weeks. However, this request is for an unknown length of use which is not consistent with guidelines. Therefore, this request is not medically necessary.

**Cold Therapy Unit, Left Shoulder QTY: 1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Online Version, Continuous-flow cryotherapy.

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

**Decision rationale:** The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The use of a cold therapy unit would be reasonable for 7 days post-operatively. However, this request is for an unknown length of use which is not consistent with guidelines. Therefore, this request is not medically necessary.