

<b>Case Number:</b>	CM15-0202560		
<b>Date Assigned:</b>	10/19/2015	<b>Date of Injury:</b>	06/23/2014
<b>Decision Date:</b>	12/23/2015	<b>UR Denial Date:</b>	09/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2015

### 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: New York

Certification(s)/Specialty: Anesthesiology

### 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 injured worker is a 60 year old female who sustained an industrial injury on June 23, 2014. The worker is being treated for: "chronic left shoulder strain"; impingement syndrome, rotator cuff tear, and shoulder pain. Subjective: August 07, 2014, continued discomfort to right anterior shoulder; "feels tired and taut." November 05, 2014 states "physical therapy making pain worse." March 23, 2015, "improved range of motion," and continues "to have pain and limitation in motion with ADLs." Objective: November 05, 2014 "significant pain with impingement." Medications: October 29, 2014: Norco, and discontinued Ultram and will "attempt to dispense Anaprox." November 05, 2014 NSAIDs as needed. Diagnostics: pending MRI right shoulder. Treatment: modified activities, November 05, 2014 administered Toradol injection subacromial space (noted "was not helpful." physical therapy session, January 23, 2015 underwent right shoulder arthroscopy; home exercise program. On September 11, 2015 a request was made for manipulation under general anesthesia and injection right shoulder which was noncertified by Utilization Review on September 18, 2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CPM (4 week rental) Right Shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The post-operative continuous passive motion (CPM) unit is used to prevent adhesions, facilitate range of motion, and to improve recovery. According to the ODG, continuous passive motion (CPM) is not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. In this case, there is no documentation the patient is to undergo any further surgical intervention for the right shoulder. There is no specific indication for CPM at this time. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

**Optimum Rehab Kit (Purchase) Right Shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** According to the ODG, exercise is recommended. There is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise. There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. A therapeutic exercise program should be initiated at the start of any treatment or rehabilitation program, unless exercise is contraindicated. Such programs should emphasize education, independence, and the importance of an on-going exercise regime. Home exercise programs are usually designed without the need for specialized equipment. In this case, there is no documentation of specific equipment necessary for home exercise. Medical necessity for the requested home exercise kit has not been established. The requested item is not medically necessary.

**Abduction Sling (Purchase) Right Shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Post-operative abduction pillow sling.

**Decision rationale:** According to the ODG, an abduction pillow sling is recommended as an option following open repair of large and massive rotator cuff tears and other shoulder surgeries. The sling/abduction pillow keeps the arm in a position that takes tension off the repaired tendon. Abduction pillows for large and massive tears may decrease tendon contact to the prepared sulcus but are not used for arthroscopic repairs. In this case, there is no specific indication of the surgical procedure proposed at this time. Medical necessity for the requested has not been established. The requested item is not medically necessary.

**Post-operative Physical Therapy 2 x 4 week, Right Shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004, and Postsurgical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine, and Postsurgical Treatment 2009, Section(s): Shoulder.

**Decision rationale:** According to ACOEM Guidelines, post-surgical physical medicine treatment frequency is dependent on the type of surgery performed. For extensor tendon repair or tenolysis, there is an allowance of 18 visits over 4 months within the first 6 months after surgery. An initial course of 9 visits is recommended and the remaining 9 would be appropriate if the patient demonstrates functional improvement. Functional improvement is defined as clinically significant benefit with regards to daily activities or work improvement documented during the patient's post-operative evaluations. In this case, there is no documentation of the proposed surgical procedure. Medical necessity for the requested services has not been established. The requested services are not medically necessary.

**Manipulation under Anesthesia:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations.

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

**Decision rationale:** According to the ODG, shoulder manipulation under anesthesia (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), MUA may be considered. There is some support for MUA in adhesive capsulitis, based on consistent positive results from multiple studies, although these studies are not high quality. In this case, while the patient has failed conservative therapy, there is no documentation indicating that this care was carried out for 3-6 months. In this case, the patient has failed conservative care, however, there is no indication that this care was done for 3-6 months. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

**Injection Right Shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Diagnostic Criteria.

**Decision rationale:** According to ACOEM guidelines, subacromial injection may be indicated after a trial of conservative treatment when there is continued pain with rotation that significantly limits activities. The ODG states that the indications for injection include adhesive capsulitis, impingement syndrome, or rotator cuff problems. Injection may be an option when conservative treatment of at least 3 months fails to control symptoms and pain interferes with functional activities. The injections are generally performed without fluoroscopic or ultrasound guidance. In this case, the patient has failed conservative care, however, there is no indication that this care was done for 3-6 months. Medical necessity for the requested shoulder injection has not been established. The requested procedure is not medically necessary.