

<b>Case Number:</b>	CM15-0051320		
<b>Date Assigned:</b>	04/15/2015	<b>Date of Injury:</b>	10/01/2014
<b>Decision Date:</b>	06/02/2015	<b>UR Denial Date:</b>	03/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/18/2015

### 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: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

### 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 55 year old female, who sustained an industrial injury on 10/01/2014. The injured worker was diagnosed as having right shoulder sprain/strain and frozen shoulder. Treatment to date has included right shoulder injection, physical therapy, oral medications and activity restrictions. The injured worker presented on 12/19/2014, for a comprehensive orthopedic consultation. It was noted that the injured worker sustained continuous trauma to the left upper extremity occurring from 06/2011 until 06/2012. The injured worker had failed all attempts at aggressive conservative management in the form of a cortisone injection, various anti-inflammatory medications, and analgesic medication. The injured worker reported a pain level of 9/10. Upon examination of the right shoulder, there was 180 degree forward flexion and abduction, 50 degree extension and adduction, and 90 degree external and internal rotation. There was negative orthopedic testing, negative tenderness to palpation, and 5/5 motor strength. Upon examination of the left shoulder, there was limited range of motion, 4/5 motor weakness, severe supraspinatus tenderness, moderate greater tuberosity tenderness, moderate AC joint tenderness, and positive ortho testing. An ultrasound study of the left shoulder dated 05/08/2014, revealed AC joint degenerative disease, with a high grade partial thickness rotator cuff tear, and subacromial fibrosis with adhesion formation/impingement syndrome. The physician recommended arthroscopic evaluation of the left shoulder, with subacromial decompression, distal clavicle resection and rotator cuff debridement, and/or repair. A Request for Authorization form was submitted on 12/19/2014, for the requested left shoulder surgery.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Manipulation under anesthesia and possible diagnostic arthroscopy with capsular release and repair of damaged structures, right shoulder:** 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.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Manipulation under anesthesia.

**Decision rationale:** The CA MTUS/ACOEM Practice Guidelines state a referral for surgery consultation may be indicated for patients who have red flag conditions, activity limitation for more than 4 months, failure to increase range of motion and strength after exercise programs, and clear clinical and imaging evidence of a lesion. According to the Official Disability Guidelines, manipulation under anesthesia is currently under study for adhesive capsulitis. In cases that are refractory to conservative therapy lasting 3 to 6 months where range of motion remains significantly restricted, or abduction is less than 90 degrees on examination, manipulation under anesthesia may be considered. The current request for a right shoulder manipulation under anesthesia with possible diagnostic arthroscopy, capsular release and repair of damaged structures would not be supported in the absence of a significant functional deficit with regard to the right shoulder. The injured worker reports 9/10 pain involving the left shoulder. The injured worker has been previously treated with a cortisone injection and medications for the left shoulder. There is no mention of a recent attempt at any conservative treatment, including active rehabilitation. In addition, the injured worker has normal range of motion with negative, orthopedic testing, involving the right shoulder. The medical necessity for a right shoulder procedure has not been established. Given the above, the request is not medically appropriate at this time.

**Associated surgical services: Cryotherapy:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical services: Shoulder abduction pillow/sling, 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 cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Post-op physical therapy, 5 times weekly for 2 weeks then 3 times weekly for 4 weeks, 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 cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical services: EKG:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical services: CBC (complete blood count):** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical services: CMP (comprehensive metabolic panel):** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical services: PT (prothrombin time): Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Associated surgical services: PTT (partial thromboplastin time): Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.