

<b>Case Number:</b>	CM15-0083326		
<b>Date Assigned:</b>	05/05/2015	<b>Date of Injury:</b>	06/23/2014
<b>Decision Date:</b>	06/30/2015	<b>UR Denial Date:</b>	04/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/30/2015

### 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: Minnesota, Florida

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:

The injured worker is a 46 year old female, who sustained an industrial injury on 6/23/14. She has reported initial complaints of a pinch pain in the right biceps area after grabbing a door before it closed. The diagnoses have included right shoulder severe adhesive capsulitis, right shoulder tendinosis versus partial thickness tear, right shoulder arm/injury and right elbow lateral epicondylitis. Treatment to date has included medications, heat, activity modifications, off of work, physical therapy, bracing, acupuncture which was not beneficial and home exercise program (HEP). Currently, as per the physician progress note dated 2/24/15, the injured worker complains of intermittent pain in the right shoulder with limited and painful movement. There is pain in the right elbow with movement and decreased range of motion. There is reported pain in the right wrist/hand and fingers with numbness and tingling in the fingers. The physical exam of the right shoulder revealed tenderness to palpation in the lateral and anterior aspects, flexion and external rotation is limited and active and passive range of motion is limited. The current medications included Norco and Motrin. The diagnostic testing that was performed included x-ray of the bilateral shoulders dated 10/28/14 which revealed no acute fractures or dislocations, type III acromion morphology on both sides and degenerative changes in the acromioclavicular joint bilaterally. Magnetic Resonance Imaging (MRI) of the right shoulder dated 12/11/14 revealed tendinosis versus partial thickness tear involving the distal fibers of the supraspinatus tendon without definite tear. There was previous physical therapy notes noted in the records. The work status was modified with work restrictions effective 2/24/15. The physician requested treatments included Right shoulder surgery manipulation under anesthesia, Pre-operative medical

clearance, Post-operative physical therapy 2 times a week for 12 weeks to the right shoulder quantity of 24.00 and Post-operative cold therapy unit (in days) quantity of 10.00.

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

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

#### **Right shoulder surgery manipulation under anesthesia: Overturned**

**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:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Manipulation under anesthesia.

**Decision rationale:** The injured worker has been symptomatic since 6/23/2014 and has been treated with physical therapy and a home exercise program. The documentation indicates that physical therapy aggravated her symptoms and therefore it was stopped. She initially had impingement symptoms and findings and then developed progressive adhesive capsulitis. X-rays revealed a type III acromion and acromioclavicular arthritis. The provider has requested manipulation under anesthesia with possible capsular release prior to additional arthroscopic surgery. The MRI scan of the right shoulder dated 12/11/2014 revealed moderate hypertrophic changes of the acromioclavicular joint, increased T2 signal in the distal fibers of the supraspinatus tendon at its insertion on the greater tuberosity and extending to CM proximally. The impression was tendinosis versus partial thickness tear involving the distal fibers of the supraspinatus tendon. No definite labral tear was seen. The documentation from April 7, 2015 indicates constant bilateral shoulder pain associated with painful movement. The pain radiated down to the right hand with numbness noted in 3 fingers. She also complained of right elbow pain. On examination the right shoulder was tender to palpation over the posterior and lateral aspect. Flexion was limited to 70 active as well as passive. External rotation was 5 compared to 60 on the opposite side. The diagnosis was severe adhesive capsulitis of the right shoulder, tendinosis versus partial thickness rotator cuff tear involving the distal fibers of the supraspinatus tendon and right lateral epicondylitis. The injured worker has had physical therapy and a home exercise program but no corticosteroid injections are documented. The procedure requested is manipulation under anesthesia versus arthroscopic capsular release. The initial denial on 3/23/2015 was based upon other issues that would not be addressed by manipulation under anesthesia including evidence of impingement, type III acromion, lack of a subacromial injection for diagnostic and therapeutic benefit, and absence of a physical examination with range of motion documentation. The provider subsequently explained that active and passive flexion was 70 and external rotation 5. The provider also explained that he was planning a 2 stage procedure with the first stage being manipulation under anesthesia and the second stage involving a subacromial decompression, and partial claviclectomy. The utilization review denial the second time was based upon lack of documentation of a comprehensive exercise rehabilitation program and non-operative treatment protocol with documented failure. ODG guidelines indicate that manipulation under anesthesia 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. There is some support for manipulation under anesthesia in adhesive capsulitis based on consistent positive results from multiple

studies, although these studies are not high- quality. Manipulation under anesthesia for frozen shoulder may be an effective way of shortening the course of this apparently self-limiting disease and should be considered when conservative therapy has failed. The available documentation indicates that conservative therapy has included physical therapy with associated failure and a subsequent home exercise program. Corticosteroid injections have not been utilized. However, the range of motion remains significantly restricted and refractory to conservative therapy with the symptoms lasting approximately a year. As such, the medical necessity of manipulation under anesthesia has been established. The request is medically necessary.

**Pre-operative medical 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), Low Back Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Section: Low Back, Topic: Pre-operative testing, general, Topic: Office visits.

**Decision rationale:** ODG guidelines recommend a history and physical examination with selective testing based on the clinician's findings. If there are significant comorbidities, office visits to the offices of medical doctors are recommended as determined to be medically necessary. The documentation provided does not indicate the presence of significant comorbidities that would necessitate medical clearance. Manipulation under anesthesia is an outpatient procedure which is considered low risk. Routine medical clearance for low risks procedures in the absence of significant risk factors is not recommended. As such, the request for medical clearance has not been substantiated. Therefore the request is not medically necessary.

**Post-operative physical therapy 2 times a week for 12 weeks to the right shoulder qty: 24.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

**Decision rationale:** California MTUS postsurgical treatment guidelines indicate 24 visits over 14 weeks for adhesive capsulitis. The initial course of therapy is one half of these visits which is 12. Then with documentation of continuing functional improvement, a subsequent course of therapy of the remaining 12 visits may be prescribed. The request as stated is for 24 visits which are not supported by guidelines. As such, the request is not medically necessary and has not been substantiated.

**Post-operative cold therapy unit (in days) qty: 10.00:** 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:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Section: Shoulder, Topic: Continuous flow cryotherapy.

**Decision rationale:** ODG guidelines recommend continuous-flow cryotherapy for shoulder surgery postoperatively for 7 days. It reduces pain, swelling, inflammation, and need for narcotics after surgery. Use beyond 7 days is not recommended. The request as stated is for 10 days which exceeds the guideline recommendations. As such, the request is not medically necessary and has not been substantiated.