

<b>Case Number:</b>	CM14-0166194		
<b>Date Assigned:</b>	10/13/2014	<b>Date of Injury:</b>	03/03/2011
<b>Decision Date:</b>	11/13/2014	<b>UR Denial Date:</b>	09/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/08/2014

### 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 Orthopedic Surgery and is licensed to practice in Texas. 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:

The injured worker is a 58-year-old male with a date of injury of March 3, 2011. Injury occurred relative to repetitive use of the upper extremities. Past surgical history was positive for left shoulder arthroscopy with subacromial decompression, acromioplasty, Mumford procedure, superior labral tear from anterior to posterior repair, and rotator cuff repair on April 2, 2014. The July 29, 2014 physical therapy note documented completion of 27 post-op physical therapy visits. The injured worker had been progressing slowly, but he felt some motions, like behind the back, had not improved in the last 3 to 4 weeks. Physical exam documented left shoulder active flexion 115 degrees. The September 8, 2014 treating physician report cited neck, upper back and shoulder pain. In particular, there was left shoulder pain and difficulty with range of motion. He reported pain and burning sensation in both hands and arms and difficulty with grip and grasp. He had gone through some physical therapy but there was a lot of muscle tightness and the injured worker felt massage therapy would be helpful. Physical exam documented limited left shoulder range of motion, paracervical tenderness, and palpable left trapezius spasms. There was painful cervical range of motion and paralumbar tenderness. There was left anterior shoulder tenderness with positive impingement sign. The diagnosis was left shoulder impingement. The injured worker had exhausted conservative treatment and would benefit from surgery. Referral to the orthopedic surgeon was recommended. Massage therapy was recommended for 6 visits to the upper back. Authorization was requested for left shoulder arthroscopic lysis of adhesions, capsular release and manipulation under anesthesia. The September 29, 2014 utilization review denied the left shoulder surgery and associated requests due to insufficient info regarding the diagnosis of adhesive capsulitis, the amount of conservative treatment relative to number of physical therapy visits and outcome, use of oral or injectable medications and outcome, and progress made since rehab began relative to range of motion.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder arthroscopic lysis of adhesions, capsular release, MUS (manipulation under anesthesia): 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, Surgery for adhesive capsulitis; 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 Official Disability Guidelines (ODG), Shoulder, Surgery for adhesive capsulitis

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines do not provide recommendations for surgery for adhesive capsulitis. The Official Disability Guidelines state that arthroscopic release of adhesions and manipulation under anesthesia are under study. There is some evidence to support arthroscopic release of adhesions for cases failing at least 3 to 6 months of conservative treatment. Manipulation under anesthesia may be considered when range-of-motion remains significantly restricted (abduction less than 90), following conservative treatment. Guidelines support the use of physical therapy and injections for injured workers with adhesive capsulitis. Guideline criteria have not been met. There is no current documentation relative to left shoulder range of motion (including abduction) or current diagnosis of adhesive capsulitis. Evidence of 3 to 6-months of a recent, reasonable, and/or comprehensive non-operative treatment protocol trial, including medications and injections, and failure has not been submitted. Therefore, this request is not medically necessary.

**Preoperative EKG (electrocardiogram): 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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3): pages 522-538

**Decision rationale:** As the surgical request is not supported, this request for a pre-operative electrocardiogram is not medically necessary.

**Preoperative Labs: 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), Criteria for preoperative lab testing

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3): pages 522-38

**Decision rationale:** As the surgical request is not supported, this request for pre-operative labs is not medically necessary.

**Preoperative medical clearance:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.guideline.gov/content.aspx?id=38289> and on the Non-MTUS Institute for Clinical Systems Improvement, 1997 Sep (revised 2012 Jul), Preoperative evaluation

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3): pages 522-38

**Decision rationale:** As the surgical request is not supported, the request for pre-operative medical clearance is not considered medically necessary.

**Smart sling with abduction pillow:** 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, Postoperative abduction pillow sling

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

**Decision rationale:** As the surgical request is not supported, the request for a smart sling with abduction pillow is not medically necessary.

**Cold therapy unit:** 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, 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:** As the surgical request is not supported, the request for a cold therapy unit is not medically necessary.

**Assistant PA (Physicians Assistant):** 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, Surgical Assistant

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare and Medicaid services, Physician Fee Schedule, 2014

**Decision rationale:** As the surgical request is not supported, the request for a physician assistant is not medically necessary.