

Case Number:	CM14-0219316		
Date Assigned:	01/09/2015	Date of Injury:	05/12/2011
Decision Date:	03/10/2015	UR Denial Date:	12/16/2014
Priority:	Standard	Application Received:	12/31/2014

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. 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: Ohio, West Virginia

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Medical Toxicology

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 was a 62 year old male, who sustained an industrial injury, on February 15, 2011. The injured worker suffers from left shoulder, cervical spine, left wrist and hand pain. The chief complaint was left shoulder pain; which were rated 6 out of 10; 0 being no pain and 10 being the worse pain. The injured worker was diagnosed with adhesive capsulitis of the left shoulder, cervical spine sprain/strain, left hand sprain/strain with positive carpal tunnel syndrome, herniated lumbar disc with radiculopathy and headaches. The injured worker had a nerve conduction study which showed left hand carpal tunnel syndrome. On July 28, 2014 the injured worker had left shoulder arthroscopic surgery. Prior to the July 28, 2014 surgery the injured worker had physical therapy for 4 months, and injection which gave good temporary relief from pain. The injured worker was taking pain medication. According to the progress note of October 7 2017, postoperative physical therapy, after arthroscopic left shoulder surgery on July 28, 2014, there was no progress in range of motion with physical therapy. On October 7, 2014, the primary treating physician requested left shoulder manipulation under anesthesia with immediate physical therapy and CPM machine. The procedure was prescribed primarily to improve the injured worker's functional capability and provide significant pain relief. On December 16, 2014, the UR denied authorization for postoperative physical therapy, hot/cold contrast unit, left shoulder manipulation under anesthesia with injection and continuous passive motion machine. The denial; was based on the MTUS ACEOM guidelines for Occupational Medical Practice Guidelines for surgical considerations- Shoulder Complaints.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder manipulation under anesthesia with injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation shoulder, manipulation under anesthesia

Decision rationale: ODG states that shoulder manipulation under anesthesia is recommended "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. Manipulation under anesthesia (MUA) for frozen shoulder may be an effective way of shortening the course of this apparently self-limiting disease and should be considered when conservative treatment has failed. The provided medical records note significantly reduced range of motion but nowhere does the treating physician describe conservative therapies. There are notations regarding the use of chiropractic manipulation but this seems to have been directed at the neck and back complaints not the shoulder. Without a sustained course of conservative therapy documented the cited treatment guidelines do not recommend this course of therapy. As such, the request for shoulder MUA is deemed not medically necessary.

Associated surgical service: Post-op physical therapy: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 196-219, Chronic Pain Treatment Guidelines Physical therapy, physical medicine Page(s): 98-99, Postsurgical Treatment Guidelines Page(s): 26-27. Decision based on Non-MTUS Citation Shoulder (Acute & Chronic), Physical therapy

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. For adhesive capsulitis, post procedure up to 24 PT visits are recommended by the above cited guidelines, with an initial period of 12 visits. The request does not document the requested number of physical therapy visits; further post op physical therapy must be preceded by the operative procedure in question. As that procedure has been deemed not appropriate at this time, the request for post-op physical therapy is likewise deemed not medically necessary.

Associated surgical service: Hot/cold contrast 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, Cold Compression Therapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder, Cryotherapy and Continuous-flow cryotherapy, cold compression

Decision rationale: ODG states in regard to continuous cryotherapy; Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be 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; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. In regard to cold compression therapy ODG states; "Not recommended in the shoulder." Even if only utilized for cryo therapy the duration of use is not included in the request, whether the request is for rental or purchase is also not included. Given that it is a compression device as well it is unlikely that it is intended only for thermal therapy and that it is to be used as a compression device and as such is not recommended for use in the shoulder. The hot cold contrast unit is deemed not medically necessary.

Associated surgical service: Continuous passive motion machine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Continuous Passive Motion

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

Decision rationale: ODG states regarding CPM; Not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. The duration of use is not included in the request nor is whether the durable equipment is for purchase or rental. Further, this device is requested as an associated surgical service and the procedure which its' use was asked for following has been deemed not medically necessary. There is also no documentation previous therapies used or of plan for therapeutic use of this device in conjunction with other therapies. As such, the request for a continuous passive motion machine is deemed not medically necessary.