

<b>Case Number:</b>	CM15-0019887		
<b>Date Assigned:</b>	02/09/2015	<b>Date of Injury:</b>	11/11/2013
<b>Decision Date:</b>	04/14/2015	<b>UR Denial Date:</b>	01/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/02/2015

### 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: Illinois, California, Texas  
 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 45-year-old female who sustained an industrial injury on 11/11/13, due to cumulative trauma and tossing a ball with a child. Records documented a course of physical therapy for 15 visits and a home therapy program. Medications included anti-inflammatories and muscle relaxants. The 3/21/14 right shoulder MR arthrogram impression documented an old fracture deformity of the humeral head, marked decrease in size of the anterior inferior labrum that may be developmental or due to an old tear, and marked thinning of the middle glenohumeral ligament compatible with an old tear. The 11/6/14 treating physician report cited persistent right shoulder pain and dislocation, and right hip pain. Medications allowed her to function. Right shoulder exam documented anterior tenderness to palpation, reduced flexion and abduction range of motion, and positive impingement test. Lumbar spine exam documented paravertebral muscle tenderness, spasms, and restricted range of motion. Straight leg raise was positive on the right and sensation was reduced in the right S1 dermatomal distribution. Right hip exam documented tenderness to palpation over the greater trochanter and slightly reduced range of motion in flexion and abduction. The treatment plan recommended continued medications, continued home therapy, CT scan of the right shoulder, and orthopedic surgeon follow-up. The 11/18/14 medical legal report documented a diagnosis of right shoulder strain with aggravation of pre-existing occult instability, right greater trochanteric bursitis, and lower back pain. Right shoulder exam documented severe guarding with exquisite tenderness wherever she was touched, and voluntary limitation of range of motion. Apprehension and relocation tests could not be performed as the injured could not relax. There was no evidence of muscle atrophy, swelling,

crepitus, and impingement signs were negative bilaterally. Low back exam was unremarkable. A right hip exam was not documented. The examiner felt the patient probably had an occult anterior instability of the right shoulder and opined the examinee should have surgery to assess and correct the anterior instability problem. A right hip injection followed by physical therapy was recommended. The 1/5/15 utilization review non-certified the request for right shoulder arthroscopy as there were no details of specific right shoulder injury and conservative treatment. The request for physical therapy to the right hip shoulder and low back was denied as there was no specific documentation of prior therapy outcomes.

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

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

#### **Right shoulder arthroscopy: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder; Diagnostic arthroscopy; Shoulder dislocation surgery.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

**Decision rationale:** The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. MTUS guidelines indicate that surgery for shoulder dislocation can be considered for patient who are symptomatic with all overhead activities, have had two or three episodes of dislocation, and instability has limited their activity between episodes. Guideline criteria have not been met. The patient presents with right shoulder pain. Clinical exam was limited by severe guarding. There is imaging evidence of an old fracture deformity of the humeral head with findings consistent with old glenohumeral ligament and labral tears. Occult anterior instability has been optioned but not demonstrated on exam. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial for the right shoulder and failure has not been submitted. Therefore, this request is not medically necessary.

#### **Physical Therapy 3x3 right hip, right shoulder and low back: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines: Physical therapy; Shoulder, Low Back, Hip & pelvis.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Introduction, Physical Medicine Page(s): 9, 98-99.

**Decision rationale:** The California MTUS guidelines recommend therapies focused on the goal of functional restoration rather than merely the elimination of pain. The physical therapy guidelines state that patients are expected to continue active therapies at home as an extension of treatment and to maintain improvement. Guideline criteria have not been met for the totality of this request. Directed physical therapy for the right shoulder to address range of motion and strengthening would be reasonable. However, there is no documentation of functional treatment goals or a specific functional deficit relative to the low back or right hip to support the medical necessity of requested supervised physical therapy over continued home exercise. Therefore, this request is not medically necessary.