

<b>Case Number:</b>	CM15-0075693		
<b>Date Assigned:</b>	04/28/2015	<b>Date of Injury:</b>	12/02/2010
<b>Decision Date:</b>	05/27/2015	<b>UR Denial Date:</b>	04/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/21/2015

### 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 37-year-old female with a date of injury of 12/2/2010. She has been evaluated by Cardiothoracic surgery, Neurology, and Orthopedics. The diagnoses include Thoracic Outlet Syndrome, Migraine, and Adhesive Capsulitis of the left shoulder. An MRI of the left shoulder dated 8/15/2011 revealed mild supraspinatus tendinopathy without evidence of a tear and a probable full-thickness SLAP tear in the posterior labrum. No recent imaging studies were provided. A narrative primary treating physician's follow-up visit on 4/3/2015 includes a request for authorization for "left shoulder surgery reconstruction with [REDACTED]". The request indicates that the injured worker had cortisone injections, she has a labral tear and instability and apprehension and has failed extensive conservative care and is motivated to proceed. She has migraine, neck pain, shoulder pain, upper back pain and occipital headaches. She had profound weakness with minimal use of the left arm in simple grasping. Thoracic outlet vest was helpful. Her shoulder is unstable and when she tries to reach up it dislocates and she has muscle spasms. She has a left ulnar nerve injury with weakness and pinching in the hand. Pain range was 3-8/10. On examination she was tender in the left cervical occipital muscles and left neck. She was tender over the left elbow ulnar nerve with positive elbow flexion testing. A specific orthopedic examination of the left shoulder is not included. The diagnosis was cervical sprain, thoracic outlet syndrome, bilateral upper extremity radiculopathy-neuropathy, bilateral ulnar neuritis, chronic pain, left shoulder sprain/strain, probably secondary to thoracic outlet syndrome with possible underlying shoulder derangement, labral tear. Orthopedic notes from [REDACTED] dated January 26, 2015 indicate a pain level of 2/10, active shoulder range of

motion of the left shoulder: 120/90/45/T10 and passive elevation 160. She was tender to palpation over the left trapezius. Hawkins and Neer were negative. Speed's was mildly positive. O'Brien positive. Apprehension negative. Rotator cuff strength 5/5. The diagnosis was adhesive capsulitis and superior glenoid labrum lesion and thoracic outlet syndrome. The documentation indicates that treatment options were discussed in detail. She understood that arthroscopy of the shoulder with lysis of adhesions, manipulation under anesthesia, and debridement of the SLAP tear may exacerbate her thoracic outlet syndrome. No additional orthopedic notes have been provided and there is no documentation of a recent comprehensive nonoperative treatment protocol for adhesive capsulitis with injections and an exercise rehabilitation program under the supervision of a physical therapist. A recent orthopedic examination with range of motion is also not documented. The surgical request was noncertified by utilization review citing ODG guidelines. There is also a request for meclizine which was noncertified as there is no documentation of secondary vertigo. These have now been appealed to an independent medical review.

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

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

**Meclizine 25mg #60:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medline Plus, US National Library of Medicine: Meclizine.

**Decision rationale:** With regard to the request for meclizine, Medline Plus, US National Library of Medicine indicates that it is an antihistamine that is used to prevent and treat nausea, vomiting, and dizziness caused by motion sickness. It also treats vertigo caused by inner ear problems. The documentation provided does not indicate the presence of motion sickness or inner ear problems. As such, the request for Meclizine 25mg #60 is not supported and is not medically necessary.

**Left shoulder surgery reconstruction:** Upheld

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

**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, surgery for adhesive capsulitis.

**Decision rationale:** The Orthopedic diagnosis provided for the left shoulder is Adhesive capsulitis. 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 with abduction less than 90, manipulation under anesthesia may be considered. The clinical course of adhesive capsulitis is considered self-limiting and conservative treatment including physical therapy and NSAIDs as well as injections is recommended. There is some evidence to support arthroscopic release of adhesions for cases failing conservative treatment. In the absence of a recent orthopedic examination documenting orthopedic findings pertaining to the shoulder as well as active and passive range of motion and in the absence of a recent comprehensive rehabilitation program for adhesive capsulitis, the request for manipulation under anesthesia and arthroscopic lysis of adhesions is not supported, particularly in light of the opinion of the surgeon that the procedure may exacerbate the underlying condition of thoracic outlet syndrome. The provider has requested "left shoulder surgery reconstruction with [REDACTED]". Although there is no specific surgical procedure requested, [REDACTED] consultation report is utilized for this purpose. In light of the foregoing, the requested surgical procedure for the left shoulder is not supported and is not medically necessary.