

<b>Case Number:</b>	CM15-0078522		
<b>Date Assigned:</b>	04/29/2015	<b>Date of Injury:</b>	12/27/2003
<b>Decision Date:</b>	06/04/2015	<b>UR Denial Date:</b>	04/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/24/2015

### 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: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

### 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 53-year-old female, who sustained an industrial injury on 12/27/2003. The mechanism of injury involved a motor vehicle accident. The injured worker was diagnosed as having disorders of cervical disc displacement without myelopathy, lumbar disc displacement without myelopathy, pain in shoulder joint, psychogenic pain, lumbar lumbosacral disc degeneration, and stenosis of lumbar spine, bursae and tendons in shoulder region, and complete rupture of rotator cuff. Treatment to date has included medications, physical therapy, and left shoulder surgery. The injured worker presented on 04/03/2015 for a follow-up evaluation with complaints of persistent left shoulder pain. The injured worker reported mild generalized aching/burning pain felt at the left shoulder during complete rest. At end points, there was limited range of motion. The pain increased to a moderate to momentarily severe burning pain primarily laterally in the left shoulder. Pain was well localized without much radiation. There was no crepitus or soft tissue swelling described. The injured worker was approximately 5 months status post left shoulder arthroscopy with rotator cuff repair, decompression, and debridement of a SLAP lesion. The injured worker had completed a course of physical therapy. The current medication regimen included gabapentin, naproxen, and Norco. Upon examination of the left shoulder, there were 125 degrees of flexion, 40 degrees of extension, 120 degrees of abduction, 40 degrees of adduction, and 45 degrees of external rotation. There were positive Neer's and Hawkins signs noted. Treatment recommendations at that time included a left shoulder manipulation under anesthesia with possible left shoulder arthroscopic capsular release. There was no Request for Authorization form submitted for this review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Manipulation under Anesthesia, Possible Left Shoulder Arthroscopy with Capsular Release and Treatment of Encountered Pathology for the Left Shoulder: 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 Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Manipulation under Anesthesia.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state a referral for surgical consultation may be indicated for patients who have red flag conditions, activity limitations for more than 4 months, failure to increase range of motion and strength after exercise programs, and clear clinical and imaging evidence of a lesion. According to the Official Disability Guidelines, manipulation under anesthesia is currently under study as an option in adhesive capsulitis. In cases that are refractory to conservative therapy lasting at least 3 to 6 months where range of motion remains significantly restricted less than 90 degrees, manipulation under anesthesia may be considered. In this case, the injured worker's physical examination only revealed slightly limited range of motion with positive Neer's and Hawkins signs. Abduction was noted at 120 degrees. There were no recent imaging studies provided for review. There was no mention of an exhaustion of all conservative management prior to the request for an additional surgical procedure. Manipulation under anesthesia would not be supported in this case. Given the above, the request is not medically necessary.

**Physician's Assistant: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

### **Postoperative Physical Therapy (3 times a week for 2 weeks than 2 times a week for 3 weeks): Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Cold Therapy Unit:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Cradle Sling/Abduct Pillow for the Left Shoulder:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.