

Case Number:	CM13-0028858		
Date Assigned:	06/06/2014	Date of Injury:	06/15/2012
Decision Date:	07/29/2014	UR Denial Date:	08/19/2013
Priority:	Standard	Application Received:	09/25/2013

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 California. 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:

This 59-year-old female mailroom clerk sustained an industrial injury on 6/15/12, relative to repetitive use. Past medical history was positive for obesity, diabetes, and hypertension. The 2/22/13 right shoulder MRI impression documented revealed thinning with interstitial tearing supraspinatus anterior margin by 50% involvement, acromioclavicular (AC) joint degenerative with downsloping acromion reflective of chronic impingement, and minor biceps tendinosis, and glenohumeral joint synovitis. Conservative treatment included activity modification, physical therapy, acupuncture, injection, and anti-inflammatory medications. The 8/12/13 initial orthopedic consult report documented persistent right shoulder pain despite conservative treatment. Exam findings documented loss of range of motion, positive impingement sign, and intact strength. The treatment plan recommended right shoulder arthroscopy with subacromial decompression and rotator cuff repair or debridement. The 8/19/13 utilization review denied the request for right shoulder surgery and associated services/items based on limited conservative treatment, minimal relief from subacromial injection, and minimal evidence of significant soft tissue disease to warrant surgical consideration. The 9/3/13 appeal submitted by the orthopedic surgeon stated that the patient had a history of right shoulder subacromial impingement and partial thickness supraspinatus tear. She had persistent deep pain with overhead reaching and pain at night. She had significant conservative treatment including prior corticosteroid injections. Initial injection provided 100% relief for one week; the second had only 30% effect. She had anti-inflammatories, physical therapy, and acupuncture. She was referred for orthopedic evaluation when conservative management failed. Physical exam finding documented right shoulder flexion 155 degrees, abduction 150 degrees, external rotation 80 degrees, and internal rotation to L1. There was discomfort from 90-120 degrees and 4+/5 supraspinatus strength. There was a positive Hawkin's maneuver on the right. Right shoulder x-rays demonstrated type II

acromion and AC joint hypertrophy with subchondral sclerosis. MRI findings were consistent with clinical exam. Right shoulder arthroscopy with subacromial decompression and rotator cuff repair versus debridement was again requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

OUTPATIENT RIGHT SHOULDER ARTHROSCOPY, INTRA-ARTICULAR DEBRIDEMENT, SUBACROMIAL DECOMPRESSION VERSUS ROTATOR CUFF REPAIR: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for rotator cuff repair, Surgery for impingement syndrome.

Decision rationale: The California MTUS guidelines do not provide surgical recommendations for chronic shoulder injuries. The Official Disability Guidelines for rotator cuff repair of partial thickness tears and impingement syndrome require 3 to 6 months of conservative treatment plus weak or absent abduction and positive impingement sign with a positive diagnostic injection test. Guideline criteria have been met. This patient presents with persistent right shoulder pain and functional difficulty despite guideline-recommended conservative treatment. Clinical exam findings noted painful arc of motion, pain at night, rotator cuff weakness, positive impingement sign, and a positive diagnostic injection test. There is imaging evidence of a partial thickness supraspinatus tear and findings of chronic impingement due to acromioclavicular joint degeneration. Therefore, this request for outpatient right shoulder arthroscopy, intra-articular debridement, subacromial decompression versus rotator cuff repair is medically necessary.

PURCHASE OF ONE POSTOPERATIVE ULTRASLING FOR THE RIGHT SHOULDER: 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 Official Disability Guidelines (ODG) Shoulder, Postoperative abduction pillow sling.

Decision rationale: The California MTUS are silent regarding post-op abduction pillow slings. The Official Disability Guidelines state that these slings are recommended as an option following open repair of large and massive rotator cuff tears. Guideline criteria have not been met. This patient has a partial rotator cuff tear and arthroscopic repair is planned. Guidelines generally support a standard sling for post-operative use. There is no compelling reason to support the medical necessity of a specialized abduction sling over a standard sling. Therefore,

this request for purchase of one post-operative UltraSling for the right shoulder is not medically necessary.

POST-OPERATIVE PHYSICAL THERAPY 2 TIMES PER WEEK FOR 6 WEEKS FOR THE RIGHT SHOULDER: Overturned

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

Decision rationale: The California MTUS Post-Surgical Treatment Guidelines for rotator cuff repair/acromioplasty suggest a general course of 24 post-operative visits over 14 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 12 visits. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. This request meets guideline criteria for initial post-op physical therapy. Therefore, this request for post-operative physical therapy, 2 times per week for 6 weeks for the right shoulder, is medically necessary.

PREOPERATIVE VISIT FOR PRE-OP CLEARANCE: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Academy of Orthopaedic Surgeons.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation.

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Guideline criteria have been met. Middle-aged females have known occult increased medical/cardiac risk factors. Past medical history was positive for obesity, diabetes, and hypertension. Therefore, this request for preoperative visit for pre-op clearance is medically necessary.

PREOPERATIVE LABORATORY WORK (LABS NOT SPECIFIED): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Academy of Orthopaedic Surgeons.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Practice advisory for preanesthesia evaluation: an updated report by the American

Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38.

Decision rationale: The California MTUS guidelines do not provide recommendations for this pre-operative lab testing. Evidence based medical guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. Guideline criteria have not been met. A generic request for non-specific pre-operative lab work is under consideration. There is no documentation in the file relative to the type of testing intended or patient-specific indications for those laboratory tests. Therefore, this request for preoperative laboratory work (labs not specified) is not medically necessary.

ASSISTANT SURGEON: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Academy of Orthopaedic Surgeons.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Centers for Medicare and Medicaid services, Physician Fee Schedule.

Decision rationale: California MTUS guidelines do not address the appropriateness of assistant surgeons. The Center for Medicare and Medicaid Services (CMS) provide direction relative to the typical medical necessity of assistant surgeons. The Centers for Medicare & Medicaid Services (CMS) has revised the list of surgical procedures which are eligible for assistant-at-surgery. The procedure codes with a 0 under the assistant surgeon heading imply that an assistant is not necessary; however, procedure codes with a 1 or 2 implies that an assistant is usually necessary. For this requested surgery, CPT Codes 29826 and 29827, there is a "2" in the assistant surgeon column. Therefore, based on the stated guideline and the complexity of the procedure, this request one assistant surgeon is medically necessary.