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| Case Number: | CM13-0031612 | | |
| Date Assigned: | 06/06/2014 | Date of Injury: | 10/26/2011 |
| Decision Date: | 11/19/2014 | UR Denial Date: | 09/16/2013 |
| Priority: | Standard | Application Received: | 10/03/2013 |

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 58-year-old female sustained an industrial injury on 10/26/11. The mechanism of injury was not documented. Past medical history was positive for hypertension, cardiac arrhythmia, coronary artery disease, hyperlipidemia, and gastroesophageal reflux disease. The 9/3/13 treating physician progress report cited on-going and progressive right shoulder pain, weakness and stiffness. MRI findings confirmed right shoulder impingement syndrome, acromioclavicular joint degenerative joint disease, and partial thickness versus small full thickness rotator cuff tear. Physical exam documented markedly positive Hawkin's and Neer's impingement signs with positive arc of pain from 70 to 120 degrees of forward elevation. There was no instability to anterior, inferior, or posterior ligamentous stress testing. There was 4-/5 rotator cuff weakness. Right shoulder surgery was recommended. Records indicated that this patient had failed conservative treatment and was approved for right shoulder arthroscopy versus open rotator cuff repair, decompression, resection of the coracoacromial ligament, and Mumford procedure. The 9/24/13 utilization review modified a request for cold therapy unit rental for 90-day rental to 7-day rental consistent with guidelines. The request for an electrical stimulation unit for initial 90-day rental followed by purchase was denied as not indication for post-surgical use in the shoulder. The request for a sling with large abduction pillow was denied as there was no evidence of a large or massive rotator cuff tear to meet guideline indications for use of a specialized sling. The request for a continuous passive motion unit for 45-day rental was denied as guidelines do not support use of this device of any working diagnosis. The request for an assistant surgeon was denied as not supported by the surgery planned. Pre-operative medical clearance was reported as modified with no details provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY 3 TIMES PER WEEK FOR 6 WEEKS: Upheld

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 and impingement surgery 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 for post-op physical therapy exceeds guideline recommendations for initial treatment. There is no compelling reason submitted to support the medical necessity of care beyond guideline recommendations prior to initial treatment assessment of functional benefit. Therefore, this request is not medically necessary.

COLD THERAPY 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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous flow cryotherapy

Decision rationale: The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days, including home use. The 9/24/13 utilization review decision recommended partial certification of a cold therapy unit for 7-day use. There is no compelling reason in the records reviewed to support the medical necessity of a cold device beyond the 7-day rental recommended by guidelines and previously certified. Therefore, this request is not medically necessary.

E-STIM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: The California MTUS guidelines for transcutaneous electrotherapy do not recommend the use of neuromuscular electrical stimulation (NMES) or galvanic stimulation for post-operative use. Guidelines support limited use of TENS unit in the post-operative period for up to 30 days. TENS appears to be most effective for mild to moderate thoracotomy pain. It has been shown to be of lesser effect, or not at all for other orthopedic surgical procedures. Guideline criteria have not been met. The specific type of electrical stimulation unit and clinical rationale has not been documented. There is no indication that standard post-op pain management would be insufficient. Therefore, this request is not medically necessary.

SLING WITH LARGE ABDUCTION PILLOW: 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): 205, 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Postoperative abduction pillow sling

Decision rationale: The California MTUS guidelines state that the shoulder joint can be kept at rest in a sling if indicated. The Official Disability Guidelines state that post-operative abduction pillow slings, are recommended as an option following open repair of large and massive rotator cuff tears. Guideline criteria have not been met. There is no clinical evidence of a large and massive rotator cuff tear. 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 is not medically necessary.

CONTINUOUS PASSIVE MOTION UNIT (CPM): 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, Continuous passive motion (CPM)

Decision rationale: The California MTUS are silent regarding continuous passive motion (CPM) units. The Official Disability Guidelines do not recommend CPM units for rotator cuff problems. These units are recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. Guideline criteria have not been met. Right shoulder arthroscopy versus open rotator cuff repair, decompression, resection of the coracoacromial ligament, and Mumford procedure has been approved. There is no clinical evidence suggestive of adhesive capsulitis. There is no compelling reason to support the medical necessity of this unit in the absence of guideline support. Therefore, this request 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 ASSOCIATION OF ORTHOPAEDIC SURGEONS POSITION STATEMENT REIMBURSEMENT OF THE FIRST ASSISTANT

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: The 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 there is a "2" in the assistant surgeon column for each procedure. Therefore, based on the stated guideline and the complexity of the procedure, this request is medically necessary.

PRE-OP MEDICAL CLEARANCE: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation
[HTTP://CIRC.AHAJOURNALS.ORG/CGI/CONTENT/FULL/116/17/E418](http://CIRC.AHAJOURNALS.ORG/CGI/CONTENT/FULL/116/17/E418)

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 pre-operative medical clearance. 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 given the patient's age, significant cardiac history, and risks of anesthesia. Therefore, this request is medically necessary.