MAXIMUS Federal Services

Case Number:	CM13-0042909		
Date Assigned:	12/27/2013	Date of Injury:	12/10/2003
Decision Date:	07/23/2014	UR Denial Date:	10/15/2013
Priority:	Standard	Application Received:	10/21/2013

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 78-year-old retired nurse sustained an industrial injury on December 10, 2003. The mechanism of injury is not documented. Records indicated that the patient used a motorized wheelchair to assist with fatigue that she has with ambulation and back and bilateral leg pain. She uses a cane in the right hand when ambulating. The July 16, 2012 right shoulder MRI impression documented small complete tear of the distal supraspinatus tendon with no findings to suggest significant retraction. There was moderate tendinopathy related changes involving the supraspinatus and infraspinatus tendons, and subacromial-subdeltoid and subcoracoid bursitis. There was acromioclavicular (AC) joint degenerative arthritic-type changes with spur formation along the undersurface of the clavicle and distal acromion with potential for impingement. The June 19, 2013treating physician report indicated that the patient had not been seen since November 7, 2012. Right shoulder pain had returned following a prior injection, and exam demonstrated rotator cuff impingement. A subacromial space injection was performed with temporary relief. Additional conservative treatment was attempted, including anti-inflammatory medication, physical therapy, and activity modification. The August 15, 2013 progress report indicated that the patient had failed conservative treatment and was now a surgical candidate. She was having significant right shoulder pain with 4/5 rotator cuff weakness. The October 15, 2013 utilization review conditionally non-certified the requests for right shoulder subacromial decompression and rotator cuff repair and associated services/items as additional information was necessary in order to render a decision. The provider was requested to provide the results of the MR arthrogram and subacromial injection, and the amount of pre-operative physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE RIGHT SHOULDER SUBACROMIAL DECOMPRESSION, ROTATOR CUFF REPAIR: Overturned

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; 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 and impingement syndrome require three to six months of conservative treatment plus weak or absent abduction and positive impingement sign with a positive diagnostic injection test. Guideline criteria have been met. Subjective complaints include significant right shoulder pain. There is rotator cuff weakness, positive impingement testing, and documentation of a positive injection test. Imaging findings showed a small complete supraspinatus tear and acromioclavicular joint arthritic-type changes with potential for impingement. The patient failed reasonable recent conservative treatment including physical therapy, activity modification, and anti-inflammatory medication. Therefore, this request for right shoulder subacromial decompression and rotator cuff repair is medically necessary and appropriate.

ONE ASSISTANT SURGEON: Overturned

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 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 surgical assistants. 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 one or two implies that an assistant is usually necessary. For this requested surgery, CPT Code 29826, 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 and appropriate.

ONE 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 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 surgery. Postoperative use generally may be up to seven days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. A post-operative cold therapy unit for this patient would be reasonable within the MTUS recommendations. However, this request is for an unknown duration of use is not consistent with guidelines. Therefore, this request for one cold therapy unit is not medically necessary or appropriate.

TWELVE (12) PHYSICAL THERAPY SESSIONS: Overturned

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

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

Decision rationale: The Post-Surgical Treatment Guidelines for rotator cuff repair/acromioplasty suggest a general course of 24 post-operative visits over fourteen weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or twelve 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. Guideline criteria have been met. This is an initial request for post-operative physical therapy and is consistent with guideline recommendations. Therefore this request for twelve physical therapy sessions is medically necessary and appropriate.

ONE PRE-OPERATIVE MEDICAL CLEARANCE: Overturned

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 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. This patient is 78-years-old with documentation of multiple medical problems. Therefore, this request for one pre-operative medical clearance is medically necessary and appropriate.