

Case Number:	CM13-0071469		
Date Assigned:	01/08/2014	Date of Injury:	10/17/2011
Decision Date:	04/22/2014	UR Denial Date:	12/16/2013
Priority:	Standard	Application Received:	12/27/2013

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 Family Medicine 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:

The patient injured her left shoulder at work on 10/17/2011. She has received ongoing medical care for this problem which included an MRI that was performed on 4/4/2013. The MRI was remarkable for the following: there is "impingement of the supraspinatus muscle/tendon junction with tenodesis changes." Further, there is "mild to moderate amount of fluid seen in the glenohumeral joint tracking into the subacromial space, confirming rotator cuff tear. It extends to the subdeltoid and subcoracoid bursa, consistent with bursitis." The patient was subsequently diagnosed with left shoulder impingement syndrome, subdeltoid bursitis, and partial rotator cuff tear. There is a note by [REDACTED] dated 12/2/2013. The note indicates that the patient continued to have left shoulder pain. An examination demonstrated limitation of shoulder range of motion with tenderness at the rotator cuff and a positive Hawkins test and Neer sign. The diagnosis was left shoulder impingement with a rotator cuff tear and surgery was recommended. The request for manipulation under anesthesia with open subacromial decompression and open rotator cuff tear was certified. However, there were additional requests that were not certified and included the following: the use of an assistant surgeon, a cold machine, continuous passive movement, and 24 sessions of post-operative physical therapy. The patient requested an appeal on these non-certified areas.

IMR ISSUES, DECISIONS AND RATIONALES

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

THE REQUEST FOR AN ASSISTANT SURGEON: 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 American College of Surgeons. Physicians as Assistants at Surgery, 2002. Accessed on 4/17/14 <http://www.facs.org/ahp/pubs/2002physassurg.pdf>.

Decision rationale: The American College of Surgeons; Physicians as Assistants at Surgery, 2002 study, states the following: For an arthroscopy, shoulder, surgical procedure; an assistant surgeon is "sometimes utilized" (Page 64). The available medical records do not provide any justification as to the need for the assistant surgeon. Given the lack of evidence to support the presence of an assistant surgeon and the absence of documentation for the rationale behind this request, the above issue is determined to be not medically necessary.

THE REQUEST FOR COLD MACHINE: Upheld

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

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

Decision rationale: A comprehensive review of the CA MTUS demonstrates no content on the use of a cold machine. The Shoulder Chapter of the Official Disability Guidelines comments that a cold therapy unit may be recommended as an option after surgery, but not for nonsurgical treatment. "Postoperative use generally may be up to 7 days, including home use." There is insufficient documentation in the medical record as to the rationale behind this request and the proposed duration of use. Given the lack of documentation, the above issue is determined to be not medically necessary.

THE REQUEST FOR CPM: Upheld

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

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

Decision rationale: A comprehensive review of the CA MTUS demonstrates no content on the use of Continuous Passive Motion (CPM). The Shoulder Chapter of the Official Disability Guidelines comments that Continuous Passive Motion is "not recommended for shoulder rotator cuff problems." There is insufficient documentation in the medical record as to the rationale behind this request. Given the lack of documentation and the comments in the Official Disability Guidelines, this issue is determined to be not medically necessary.

THE REQUEST FOR 24 SESSIONS OF POST-OPERATIVE PHYSICAL THERAPY:
Upheld

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 specify that for Rotator Cuff Syndrome/Impingement Syndrome: Postsurgical treatment, arthroscopic: 24 visits over 14 weeks and for Postsurgical Treatment, Open: 30 visits over 18 weeks. Further, in 9792.24. 3. Postsurgical treatment Guidelines. (a) As used in this section, the following definitions apply: "Initial course of therapy" means one-half of the number of visits specified in the general course of therapy for the specific surgery in this postsurgical physical medicine treatment recommendations set forth in subdivision (d)(1) of this section.