

Case Number:	CM14-0120350		
Date Assigned:	08/06/2014	Date of Injury:	09/18/2012
Decision Date:	09/11/2014	UR Denial Date:	07/10/2014
Priority:	Standard	Application Received:	07/30/2014

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 51-year-old male sustained an industrial injury on 9/18/12. The mechanism of injury was not documented. The patient underwent right shoulder arthroscopic subacromial decompression, mini open rotator cuff repair, and distal clavicle excision on 4/25/13. Post-operative treatment included physical therapy, home exercise program, and medications. The 5/29/14 right shoulder MR arthrogram impression documented slightly limited arthrogram due to patient's complaint of pain and status post rotator cuff repair with minimal undersurface fraying of the supraspinatus tendon. There was chronic fraying of the superoposterior labrum. The patient was status post subacromial decompression and distal clavicle resection. The 6/20/14 orthopedic report indicated the patient had persistent symptoms. The patient reported very limited range of motion and functionality. Physical exam documented slight tenderness over the anterior capsule and biceps, flexion 95 degrees, abduction 85 degrees, and some pain with rotator cuff testing. The patient had failed over a year of rest, ice, medications, therapy, bracing, and cortisone injections. Surgery was recommended to include right shoulder arthroscopy, lysis of adhesions and debridement, and manipulation under anesthesia. The 7/10/14 utilization review denied the right shoulder surgery and associated requests. The patient had not been afforded a post-operative corticosteroid injection which could be both diagnostic and therapeutic.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy, lysis of adhesions and debridement, manipulation under anesthesia: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for adhesive capsulitis.

Decision rationale: The California MTUS guidelines do not provide surgical criteria for manipulation under anesthesia or lysis of adhesions. The Official Disability Guidelines state that manipulation under anesthesia is under study as an option for adhesive capsulitis. In cases that are refractory to conservative therapy lasting at least 3-6 months where range-of-motion remains significantly restricted (abduction less than 90), manipulation under anesthesia may be considered. The use of physical therapy and injections are recommended for the treatment of adhesive capsulitis. Guideline criteria have been met. This patient presents with inability to raise his arm above shoulder level, rotate, or reaching outward causing significant functional limitations. Shoulder range of motion includes 95 degrees of flexion and 85 degrees of abduction. The patient has failed guideline-recommended conservative treatment for over a year. Therefore, this request for right shoulder arthroscopy, lysis of adhesions and debridement, and manipulation under anesthesia is medically necessary.

Surgical assistant: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://files.medical.ca.gov/pubsdoco/publications/masters-mtp/part2/surgmuscu_m01o03.doc<http://www.fchp.org/NR?rdonlyres/9FD61BA7-29B5-4350-A3F0-29B8FE5C2865/0/Assistanturgeonpaymentpoicy.pdf>http://www.bcbsnc.com/assets/services/public/pdfs/medicalpolicy/co-surgeon_assistant_surgeon_and_assistant_at_surgery_guidelines.pdf<http://www.va.gov/HAC/forbeneficiaries/champva/policymanual/chapter2/1c2s29-2.htm>.

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 23020, 29806, and 23700, there is a

"1" or "2" in the assistant surgeon column. Therefore, based on the stated guideline and the complexity of the procedure, this request for one assistant surgeon is medically necessary.

Polar Care Continuous Passive Motion (CPM) 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, Continuous Passive Motion (CPM).

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 does not provide recommendations for this device in chronic shoulder conditions. The Official Disability Guidelines state that continuous passive motion (CPM) is not recommended for shoulder rotator cuff problems or after shoulder surgery, except in cases of adhesive capsulitis. Guidelines would support use up to 4 weeks, 5 days per week. The use of a continuous passive motion unit would be reasonable for up to 4 weeks. However, this request is for an unknown length of use which is not consistent with guidelines. Therefore, this request for Polar Care continuous passive motion (CPM) machine is not medically necessary.

Postoperative Physical therapy 3 times per week for 4 weeks, 12 Total: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

Decision rationale: The California MTUS Post-Surgical Treatment Guidelines for adhesive capsulitis 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 initial post-operative treatment is consistent with guidelines. Therefore, this request for post-operative physical therapy 3x4 (12 total visits) is medically necessary.