

Case Number:	CM14-0124845		
Date Assigned:	09/25/2014	Date of Injury:	10/26/2012
Decision Date:	11/06/2014	UR Denial Date:	07/11/2014
Priority:	Standard	Application Received:	08/07/2014

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 Orthopaedic 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 71-year-old female sustained an industrial injury on 10/26/12. Injury occurred when she tripped and fell onto her left side, impacting her left shoulder on a marble table. The patient was diagnosed with a left shoulder greater tuberosity fracture and surgical neck fracture. Past medical history was positive for rheumatoid arthritis and asthma. Past surgical history was positive for partial discectomy L5/S1 in 1991. The 5/22/13 left shoulder MRI impression documented a likely chronic transverse fracture through the neck of the humerus with minimal edema along the fracture line. The superior component of the fracture extended to the posterolateral aspect of the humeral head. A transverse fracture through the posteroinferior glenoid was also noted, with no significant bone edema, consistent with a chronic fracture. There was supraspinatus tendinosis with no tear. There was severe tendinosis of the intra-articular portion of the biceps tendon, and likely partial biceps tendon tear. There was a tear of the anterior and posterior labrum, and mild glenohumeral joint chondromalacia. There were degenerative changes of the acromioclavicular joint with a lateral down sloping of the acromion. The 6/23/14 treating physician report cited continued left shoulder pain with limited range of motion and strength. She reported difficulty sleeping on the left side, doing any activity at or above shoulder level, and performing activities of daily living. X-rays were taken and demonstrated evidence of subacromial bone spur and healed greater tuberosity fracture with some slight superior displacement that appeared to be well healed. Conservative treatment had included subacromial injections and multiple rounds of physical therapy with continued symptoms of impingement. Authorization was requested for an updated left shoulder MRI and left shoulder arthroscopy, pan-capsular release, subacromial decompression, and mini-Mumford procedure. The 7/11/14 utilization review certified a request for left shoulder MRI. The left shoulder arthroscopy and associated requests were denied pending the results of imaging to establish medical necessity. The 8/6/14 treating physician

report cited continued left shoulder pain and tenderness over the anterolateral impingement area extending into the biceps area. Physical exam documented right shoulder range of motion with forward flexion 150, abduction 150, and internal/external rotation 60 degrees. There was 4/5 rotator cuff strength with supine external rotation of 60 degrees and supine internal rotation of 70 degrees. Supine internal and external rotations were very painful. Impingement tests 1 and 2 were positive. Updated MRI showed arthritic changes as well as continued labral tearing, rotator cuff tendinopathy, and large subacromial bone spur. The treatment plan again requested left shoulder surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopy, Pan-Capsular Release, SAD, Mini Mumford: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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 impingement syndrome; Partial claviclectomy

Decision rationale: The California MTUS guidelines provide a general recommendation for impingement surgery. Conservative care, including steroid injections, is recommended for 3-6 months prior to surgery. The Official Disability Guidelines provide more specific indications for impingement syndrome and acromioplasty that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of impingement are required. Guideline criteria have been met. Subjective and clinical exam findings are consistent with imaging evidence of labral tearing, rotator cuff pathology, and impingement. Evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Pre-operative Evaluation: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for pre-anesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Pre-anesthesia 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 based on patient age, magnitude of surgical procedure, recumbent position, fluid exchange and the risks of undergoing anesthesia. Therefore, this request is 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 Orthopedic Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopedics

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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 code 29826 and 29284, there is a "2" in the assistant surgeon column. Therefore, based on the stated guideline and the complexity of the procedure, this request is medically necessary.

Post Op Pt 2 X 6 Weeks: 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 is the initial request for post-operative physical therapy and is consistent with guidelines. Therefore, this request is medically necessary.

Cold Therapy Unit (Rental/Purchase): 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 Guidelines 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. The use of a cold therapy unit would be reasonable for 7 days post-operatively. However, this request is for an unknown length of use which is not consistent with guidelines. Therefore, this request is not medically necessary.

Ultrasling: 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 Immobilization

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205 and 213. 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 biceps tendon and labral 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 is not medically necessary.

Oxycontin 20 Mg #20: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Post-operative: Opioids, criteria for use, Oxycontin Page(s): 76-80 and 97.

Decision rationale: The California MTUS Guidelines indicate that Oxycontin was a controlled release formulation of Oxycodone Hydrochloride indicated for the management of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time. Oxycontin is not indicated for use as an as needed analgesic. Guideline criteria have not been met. There is no indication that this patient would require around-the-clock analgesia for an extended period of time. A request for an as needed opioid medication has been found to be

medically necessary. There is no compelling reason to support the medical necessity of an additional opioid for pain management. Therefore, this request is not medically necessary.

Vicodin 5/300 #60: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Hydrocodone/Acetaminophen Page(s): 76-80 and 91.

Decision rationale: The California MTUS guidelines typically support the use of opioids on a short term basis for shoulder pain. Guidelines recommend Vicodin for moderate to moderately severe pain on an as needed basis with a maximum dose of 8 tablets per day. Short-acting opioids, also known as "normal-release" or "immediate-release" opioids are seen as an effective method in controlling both acute and chronic pain. Guideline criteria have been met for the post-operative use of Vicodin. Therefore, this request is medically necessary.