

<b>Case Number:</b>	CM14-0136896		
<b>Date Assigned:</b>	09/03/2014	<b>Date of Injury:</b>	03/18/2008
<b>Decision Date:</b>	12/31/2014	<b>UR Denial Date:</b>	08/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/25/2014

### 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 Physical Medicine and Rehabilitation 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 42 year old female sustained an industrial related injury to the right shoulder on 03/18/2008 while working as an x-ray technician. There was no documentation of the injured workers original diagnoses and limited information regarding previous care and treatments. Current diagnoses include painful acromial at right shoulder and soft tissue mass biceps tendon sheath. Treatment to date has included injections of Xylocaine (7/29/2014) and previous acromioplasty (2008). Diagnostic testing has included a MRI of the right shoulder on 07/10/2014 which revealed a soft tissue mass of the biceps tendon in the bicipital groove, post-operative changes from acromioplasty, and low-grade focal intrasubstance tear of the posterior fibers of the supraspinatus involving less than 50% of the tendon. Objective findings upon exam, dated 07/29/2014, showed a range of motion: flexion 145, abduction 155, external rotation 90, internal rotation 45; positive tenderness over the acromion; and tenderness in the biceps tendon sheath with palpable mass at the biceps sheath just distal to the lesser tuberosity. The injured worker's pain was increased with activity. Functional deficits were unchanged and activities of daily living were worsened with difficulty sleeping and difficulty with carrying objects or overhead use. Work functions were unchanged as the injured worker remained permanent stationary. Dependency on medical care was increased with flare-up and recent findings. On 08/21/2014, Utilization Review non-certified a request for an assistant surgeon which was requested on 08/08/2014. The request for an assistant surgeon was non-certified based on the lack of complexity of the surgical procedure and the lack of need for the skills of a second surgeon and lack of exceptional factors. The American College of Surgeons - American Association of Orthopaedic Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopedics were cited. This UR decision was appealed for an Independent Medical Review. The Utilization Review also modified a prescription for a cold therapy unit x 14 days to 7 days

which was also requested on 08/08/2014. The prescription for the cold therapy unit was modified based on exceeding the recommended time guidelines for this post-surgical option. The ODG - Shoulder (Acute & Chronic) guidelines were cited. This UR decision was appealed for an Independent Medical Review. The submitted application for Independent Medical Review (IMR) requested an appeal for the non-certification of the assistant surgeon and modification of the cold therapy unit from 14 days to 7 days.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**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 Official Disability Guidelines (ODG), Lumbar Chapter, Surgical assistant.

**Decision rationale:** The patient presents with chronic right shoulder pain with positive MRI findings of soft tissue mass of biceps tendon in the bicipital groove and tear of the supraspinatus, less than 50% of the tendon. The current request is for assistant surgeon. The treating physician report dated 7/29/14 states, "Request authorization for arthroscopy right shoulder with excision of small os acromiale and debridement of biceps tendon with biceps tenodesis." The treating physician did not discuss the need for an assistant surgeon or any complexities of the case that would require an assistant surgeon. The utilization review report dated 8/18/14 authorized the requested surgery and denied the request for an assistant surgeon. The MTUS guidelines do not discuss the need for an assistant surgeon when surgery has been authorized. The ODG guidelines low back chapter do recommend an assistant surgeon for more complex surgeries. In this case, the treating physician has failed to document exactly why an assistant surgeon is required for this right shoulder arthroscopy with excision of small os acromiale and debridement of biceps tendon with biceps tenodesis. There is no documentation that the surgery is complex and this surgery does not typically require an assistant surgeon. Therefore, this request is not medically necessary.

**COLD THERAPY UNIT X 14 DAYS:** 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)

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

**Decision rationale:** The patient presents with chronic right shoulder pain with positive MRI findings of soft tissue mass of biceps tendon in the bicipital groove and tear of the supraspinatus, less than 50% of the tendon. The current request is for cold therapy unit x 14 days. The treating physician report dated 7/29/14 states under Plan, "Request authorization for arthroscopy right shoulder with excision of small os acromiale and debridement of biceps tendon with biceps tenodesis." The treating physician did not discuss the need for a cold therapy unit following the surgical procedure and the RFA form states, "Cold Therapy unit x 14 days." The ODG guidelines support continuous-flow cryotherapy only after surgery as an option for up to 7 days. In this case, the treating physician does not discuss why the patient requires usage for 14 days and the ODG guidelines only allow for continuous flow cryotherapy for up to 7 days. Therefore, this request is not medically necessary.