

<b>Case Number:</b>	CM14-0137465		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	01/13/2014
<b>Decision Date:</b>	11/12/2014	<b>UR Denial Date:</b>	08/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/26/2014

### 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 is a 30 year old male with a 1/13/14 injury date. He was working in road construction when a car hit his right hip, rolled him up onto the car, and then threw him onto the grass nearby. In a follow-up on 7/29/14, subjective findings included ongoing pain on the anterior aspect of his right shoulder. The shoulder symptoms continued to be bothersome and were affecting ADL's. The patient reported that the last cortisone injection was of minimal benefit. Objective findings included active forward flexion to 150 degrees with pain, exquisite tenderness over the biceps tendon, positive impingement signs, and positive O'Brien's. A right shoulder MRI on 3/5/14 showed a partial-thickness rotator cuff lesion and a longitudinal split tear versus possible bifid long head biceps tendon in the bicipital groove. In a 5/6/14 follow-up, the provider states that the patient has not improved after a subacromial cortisone injection and four months of physical therapy. In addition, the provider interpreted the MRI as showing a type II SLAP tear and a type III acromion with a sharp anterior edge. On 6/17/14, the patient was given a cortisone injection to the right shoulder in which half was placed into the glenohumeral joint and half was placed into the biceps tendon. Diagnostic impression: right shoulder impingement syndrome, possible right shoulder labral tear. Treatment to date: NSAIDs, physical therapy, cortisone injections. A UR decision on 8/8/14 denied the request for right shoulder arthroscopic subacromial decompression with possible SLAP repair versus biceps tenodesis on the basis that there were no imaging reports submitted to confirm the diagnosis. The requests for ice machine and surgical assistant were denied because the surgical procedure was not certified..

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right shoulder arthroscopic subacromial decompression with possible SLAP tear versus subpectoral biceps tenodesis.: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214. Decision based on Non-MTUS Citation Official Disability Guidelines, 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 Section, Surgery for Impingement Syndrome

**Decision rationale:** CA MTUS states that surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. In addition, MTUS states that surgical intervention should include clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair. Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery. ODG states that surgery for SLAP lesions is recommended for Type II lesions, and for Type IV lesions if more than 50% of the tendon is involved, in addition to a history and physical findings consistent with a SLAP lesion; recent literature suggest poor outcome with a Worker's Compensation patient population and age over 40. CA MTUS states that ruptures of the proximal (long head) of the biceps tendon are usually due to degenerative changes in the tendon. It can almost always be managed conservatively because there is no accompanying functional disability. Surgery may be desired for cosmetic reasons, but is not necessary for function. In the present case, the patient has clear symptoms and objective signs of right shoulder impingement syndrome that are confirmed with MRI findings of rotator cuff tendinosis and type III acromion. In addition, he has failed a significant period on conservative treatment that includes physical therapy and at least one subacromial cortisone injection. Therefore, the subacromial decompression portion of the request should be granted. The diagnosis of SLAP tear is less clear. There is continued shoulder pain despite a glenohumeral cortisone injection (which was separate from the subacromial cortisone injection) and there is a positive O'Brien's test on physical exam. There has been a similar failure of conservative treatment over at least 4 months, and the patient is in the appropriate age group for consideration of SLAP repair (less than 40). Although the MRI report did not confirm a SLAP tear, one would need an MR-arthrogram to really confirm this, because standard shoulder MRI's are not very sensitive for SLAP tears. In addition, the surgeon's interpretation included the likelihood of a type II SLAP tear. Given that the request is for "possible SLAP repair versus biceps tenodesis," the request as a whole can be approved with the clear understanding that the subacromial decompression is the definite part of the procedure, and a SLAP repair will only be performed if there is direct visual confirmation of a type II SLAP tear during the arthroscopy. A biceps tenodesis would only be performed in the event of a type II SLAP tear that cannot be repaired due to unforeseen technical difficulties that occur during the surgery. Therefore, the request for right shoulder arthroscopic subacromial decompression with possible SLAP repair versus subpectoral biceps tenodesis is medically necessary.

**Associated surgical service: Ice Machine purchase: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

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

**Decision rationale:** CA MTUS does not address this issue. ODG states that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. Specifically, peer-reviewed literature concludes that after carpal tunnel surgery, the use of continuous flow cryotherapy, compared with traditional ice therapy, provides patients with greater comfort and lessens the need for narcotics. However, the actual purchase of an ice machine is not recommended. Approval would normally be granted for a 7-day rental of a cold therapy unit for post-op use. In this type of review, a modified determination cannot be granted to allow for a 7-day rental instead of actual purchase of the machine. Therefore, the request for ice machine purchase is not medically necessary.

**Associated surgical service: Assistant surgeon:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214. 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 Other Medical Treatment Guideline or Medical Evidence: American Academy of Orthopedic Surgeons (AAOS)

**Decision rationale:** CA MTUS and ODG do not address this issue. American Academy of Orthopedic Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopedics states on the role of the First Assistant: According to the American College of Surgeons: "The first assistant to the surgeon during a surgical operation should be a trained individual capable of participating and actively assisting the surgeon to establish a good working team. The first assistant provides aid in exposure, hemostasis, and other technical functions, which will help the surgeon carry out a safe operation and optimal results for the patient. The role will vary considerably with the surgical operation, specialty area, and type of hospital. "The first assistant's role has traditionally been filled by a variety of individuals from diverse backgrounds. Practice privileges of those acting as first assistant should be based upon verified credentials reviewed and approved by the hospital credentialing committee (consistent with state laws)." In general, the more complex or risky the operation, the more highly trained the first assistant should be. Criteria for evaluating the procedure include:-anticipated blood loss - anticipated anesthesia time -anticipated incidence of intraoperative complications -procedures requiring considerable judgmental or technical skills -anticipated fatigue factors affecting the surgeon and other members of the operating team -procedures requiring more than one operating team. In limb reattachment procedures, the time saved by the use of two operating teams is

frequently critical to limb salvage. It should be noted that reduction in costly operating room time by the simultaneous work of two surgical teams could be cost effective. In the present case, arthroscopic subacromial decompression with possible SLAP repair is of sufficient complexity to warrant the need for an assistant surgeon. Therefore, the request for assistant surgeon is medically necessary.