

<b>Case Number:</b>	CM14-0150926		
<b>Date Assigned:</b>	09/19/2014	<b>Date of Injury:</b>	10/02/2004
<b>Decision Date:</b>	10/29/2014	<b>UR Denial Date:</b>	08/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/16/2014

### 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 49-year-old female flight attendant sustained an industrial injury on 10/2/04. Injury occurred while she was trying to stop a beverage cart from moving when the airplane hit an air pocket. The 4/25/14 left shoulder MRI impression documented supraspinatus and infraspinatus interstitial partial thickness tearing and tendinosis, glenohumeral joint effusion, and fluid within the subacromial/subdeltoid space. The 5/27/14 treating physician report documented no improvement with continued moderate pain and inability to return to work. Physical therapy to regain range of motion was requested and pain and anti-inflammatory medications were prescribed. The 6/24/14 treating physician report cited grade 7-10/10 left shoulder pain worse with reaching, motion, and stretching. Physical exam documented left shoulder flexion 90, abduction 90, and external rotation 90 degrees with 4/5 infraspinatus and supraspinatus strength. The treatment plan recommended anti-inflammatory medication, physical therapy, and arthroscopic rotator cuff repair. Records indicate that physical therapy was initiated on 7/11/14. Four visits were provided as of 7/22/14 with severe pain, marked loss of range of motion, and 3+/5 rotator cuff weakness. No change was appreciated over the initial 4 visits. The 7/22/14 treating physician report cited worsening grade 10/10 left shoulder sharp, burning left shoulder pain. Pain was improved by pain and medication, worsened with movement. Physical exam documented left shoulder range of motion limited to flexion 90, abduction 60, and external rotation 80 degrees. There was rotator cuff weakness. The diagnosis was rotator cuff tear. The treatment plan included left shoulder rotator cuff repair.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Shoulder Arthroscopy with Repair of Partial Thickness RCT with SAD: 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 rationale:** The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. For partial thickness rotator cuff tears and small full thickness tears presenting as impingement, surgery is reserved for cases failing conservative treatment for 3 months. Guideline criteria have been essentially met. Subjective and clinical exam findings are consistent with imaging evidence of rotator cuff tears. Significant pain and functional limitation are documented. Evidence of at least 3 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

**Assistant Surgeon:** Overturned

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

**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 29827 and 29826, there is a "2" in the assistant surgeon column for each procedure. Therefore, based on the stated guideline and the complexity of the procedure, this request is medically necessary.

**Post-Op Therapy X 12:** Overturned

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

**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 initial request for post-op physical therapy is consistent with guidelines. Therefore, this request is medically necessary. .

**Cold Therapy X 14 Days:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**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 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. This request for a cold therapy unit is for 14-days use which exceeds guidelines. There is no compelling reason presented to support the medical necessity of continuous flow cryotherapy is excess of guideline recommendations. Therefore, this request is not medically necessary.

**Sling:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205, 213.

**Decision rationale:** The California MTUS guidelines state that the shoulder joint can be kept at rest in a sling if indicated. Slings are recommended as an option for patients with acromioclavicular separations or severe sprains. Prolonged use of a sling only for symptom control is not recommended. Guideline criteria have been met. The use of a post-operative sling is generally indicated. Therefore, this request is medically necessary. .

**Norco 10/325mg #60 for Post-Op Pain:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212, Chronic Pain Treatment Guidelines Opioids, criteria for use, Hydrocodone/acetaminophen Page(s): 76-80, 91.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines support the use of opioids on a short term basis for wrist/hand pain. Guidelines recommend Norco 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 Norco. Therefore, this request is medically necessary.