

Case Number:	CM14-0028570		
Date Assigned:	06/16/2014	Date of Injury:	10/09/2013
Decision Date:	07/16/2014	UR Denial Date:	02/26/2014
Priority:	Standard	Application Received:	03/06/2014

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, has a subspecialty in 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 37- year-old female kitchen manager sustained an industrial injury on 10/9/13 when she slipped and fell. Initial conservative treatment included activity modification, anti-inflammatory medications, and referral to physical therapy. The 12/26/13 right shoulder MRI impression documented a type 3 acromion process with 30 degrees lateral acromial downsloping, but no significant narrowing of the subacromial space was evident. There was posterior humeral head subchondral trabecular edema consistent with bone contusion. The 1/16/14 treating physician report documented right shoulder flexion 0-90 degrees, abduction 0-95 degrees, positive drop arm test limited by pain and crepitus, painful arc of motion, pain with extremes of motion, passive external rotation 90 degrees, positive impingement sign, and positive biceps stress, Hawkins's, Neer, Speed and Yergason's tests. A subacromial injection was provided with substantial reduction in pain reported. The 1/30/14 physical therapy progress report documented completion of 12/12 physical therapy visits with no change in pain level and some improvement in shoulder abduction and external rotation range of motion. There was moderate range of motion and functional limitation documented with continued high levels of pain. The 2/13/14 treating physician progress report cited persistent right shoulder pain with no change in clinical exam findings despite cortisone injection and physical therapy. The treatment plan recommended right shoulder arthroscopy with subacromial decompression, assistant surgeon, pre-ops clearance, cold therapy unit x 7 days, and 12 positive physical therapy sessions. The 2/26/14 utilization review denied the request for right shoulder surgery and associated services as the right shoulder MRI did not demonstrate significant narrowing of the subacromial space to correlate with exam findings and warrant surgery, and there was no clear indication that conservative treatment had met guideline criteria.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 PRE OPERATIVE MEDICAL CLEARANCE BETWEEN 2/21/2014 AND 4/7/2014:

Overtured

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: Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation.

Decision rationale: Under consideration is a request for pre-operative medical clearance. The California MTUS guidelines do not provide recommendations for this service. 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. Middle-aged females have known occult increased cardiovascular risk factor to support the medical necessity of pre-operative medical clearance prior to general anesthesia. Therefore, this request for pre-operative medical clearance is medically necessary.

7 DAYS RENTAL OF A COLD THERAPY UNIT BETWEEN 2/21/2014 AND 4/7/2014:

Overtured

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: Under consideration is a request for 7 days rental of a cold therapy unit. The California MTUS are silent regarding continuous flow cryotherapy. The Official Disability Guidelines recommend continuous flow cryotherapy as an option for up to 7 days status post shoulder surgery. Guideline criteria have been met. Therefore, this request for 7 days rental of a cold therapy unit is medically necessary.

1 RIGHT SHOULDER ARTHROSCOPY WITH SUBACROMIAL DECOMPRESSION 2/21/2014 AND 4/7/2014:

Overtured

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, Surgery for impingement syndrome.

Decision rationale: Under consideration is a request for right shoulder arthroscopy with subacromial decompression. The California MTUS guidelines do not address shoulder surgeries for chronic injuries. The Official Disability Guidelines for acromioplasty generally require 3 to 6 months of conservative treatment directed toward gaining full range of motion, requiring both strengthening and stretching to balance the musculature. Criteria include subjective, objective, and imaging clinical exam findings with positive evidence for impingement including positive diagnostic injection test. Guideline criteria have been met. Subjective and objective clinical findings are consistent with imaging evidence suggestive of impingement. Positive diagnostic injection test was documented. Comprehensive conservative treatment over the course of 4 months had been tried and had failed. Therefore, this request for right shoulder arthroscopy with subacromial decompression is medically necessary.

1 ASSISTANT SURGEON BETWEEN 2/21/2014 AND 4/7/2014: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Surgeons.

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: Under consideration is a request for one assistant surgeon. California MTUS guidelines do not address the appropriateness of assistant surgeons. [REDACTED] provide direction relative to the typical medical necessity of assistant surgeons. [REDACTED] 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, there is a "2" in the assistant surgeon column. Therefore, based on the stated guideline and the complexity of the procedure, this request one assistant surgeon is medically necessary.