

Case Number:	CM14-0041083		
Date Assigned:	06/30/2014	Date of Injury:	06/15/2012
Decision Date:	07/31/2014	UR Denial Date:	03/18/2014
Priority:	Standard	Application Received:	04/08/2014

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 41-year-old female warehouse clerk sustained an industrial injury on 6/15/12. Injury was reported to the right shoulder, elbow, arm, wrist, and neck. Past medical history was negative for illness or surgeries. Records indicate the patient is overweight (body mass index 31.9). The 12/10/12 right shoulder MRI showed acromioclavicular (AC) joint degenerative changes, bursitis, and partial thickness supraspinatus tendon tear. The 2/18/14 treating physician note indicated the patient continued to have right shoulder pain despite conservative care. Treatment had included physical therapy, acupuncture, injections, and activity modification. Physical exam findings documented pain with palpation of the AC joint and subacromial bursa. There was decreased right shoulder range of motion with positive impingement and Hawkin's testing. The treatment plan recommended right shoulder arthroscopy with subacromial decompression and distal clavicle excision.

IMR ISSUES, DECISIONS AND RATIONALES

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

RNFA or PA for surgical assistant for the right shoulder surgery: 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 Statement of Principles (http://www.facs.org/ahp/pubs/2011_physasstsurg.pdf).

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 surgical assistants. 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, there is a "2" in the assistant surgeon column. Therefore, based on the stated guideline and the complexity of the procedure, this request for an RNFA or PA for surgical assistant for the right shoulder surgery is medically necessary.

Preoperative medical clearance for the right shoulder surgery: 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, Criteria for Preoperative Electrocardiogram (ECG) and Criteria for Preoperative Lab Testing.

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: 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 overweight females have known occult increased medical/cardiac risk factors. Given these clinical indications, this request for pre-operative medical clearance for the right shoulder surgery is medically necessary.

Postoperative physical therapy 3 times per week for 6 weeks for right shoulder: Upheld

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.

The 3/18/14 utilization review partially certified 12 post-operative physical therapy visits consistent with guideline recommendations for initial care. There is no compelling reason submitted to support the medical necessity of additional care beyond 12 visits. Therefore, this request for post-operative physical therapy 3 times per week for 6 weeks for right shoulder is not medically necessary.

Cold therapy device rental for 21 days for the right shoulder postoperative: 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, Continuous-flow cryotherapy.

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 surgery. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. The 3/18/14 utilization review decision recommended partial certification of this cold therapy device for 7-day use. There is no compelling reason in the records reviewed to support the medical necessity of a cold device beyond the 7-day rental recommended by guidelines and previously certified. Therefore, this request for post-operative cold therapy device rental for 21 days for the right shoulder is not medically necessary.

Ultrasling for the right shoulder postoperative: 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, Postoperative abduction pillow sling.

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

Decision rationale: The California MTUS is silent regarding post-op shoulder slings in chronic cases. The Official Disability Guidelines recommend abduction slings as an option following open repair of large and massive rotator cuff tears. Guideline criteria have not been met. Right shoulder arthroscopy with subacromial decompression and distal clavicle excision is certified. A standard sling was certified in utilization review 3/18/14; there is no compelling reason to support the medically necessary of a specialized abduction sling. Therefore, this request for a post-operative Ultrasling for the right shoulder is not medically necessary.