

Case Number:	CM14-0046299		
Date Assigned:	07/02/2014	Date of Injury:	05/07/2007
Decision Date:	08/25/2014	UR Denial Date:	04/02/2014
Priority:	Standard	Application Received:	04/14/2014

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 Pain Management & Rehabilitation, has a subspecialty in Interventional Spine 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:

The patient is a 35 year old with an injury date on 5/7/07. The patient complains of worsening right-sided shoulder pain with loss of motion and loss of sleep per 3/7/14 report. The patient received 2 subacromial injections, the first which helped trapezial area and the second which did not help per the 3/7/14 report. Based on the 3/7/14 progress report provided by [REDACTED] the diagnoses are: 1. right hand carpal tunnel release in February 2009, doing great 2. left hand carpal tunnel release in January 2010, doing well 3. disc bulges at C4-C5, C5-C6, and C6-C7 without significant neural foraminal stenosis. [REDACTED], the AME, has recommended nonsurgical intervention 4. migraine headaches, referral made to a neurologist and she is on Neurontin 5. trigger point injection in the right trapezial area on 11/23/09 without significant improvement 6. chronic thoracic strain 7. alleged psyche and sleep disorder. The patient has been evaluated by the QME [REDACTED] on 7/13/12 8. continued right shoulder pain with MRI showing supraspinatus tendinosis. Injection to the right shoulder done on 11/18/13. The patient continues to be symptomatic despite injection and physical therapy to the right shoulder consistent with impingement syndrome. An exam on 3/7/14 showed parascapular muscle spasm on the right side. Tenderness over the impingement area and over anterior trapezial area. Forward flexion is 150 degrees, abduction is 150 degrees, external rotation is 50 degrees. Supraspinatus testing is 4/5. Shoulder range of motion is worsening. [REDACTED] is requesting an assistant surgeon modified to surgical assistant, and ice machine rental purchase modified to 7 day post-op rental of cryotherapy unit. The utilization review determination being challenged is dated 4/2/14 and modifies the request for an assistant surgeon to a surgical assistant, and request for an ice machine rental/purchase to a 7 day rental of a

cryotherapy unit. [REDACTED] is the requesting provider, and he provided treatment reports from 11/7/13 to 6/2/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Assistant Surgeon modified to surgical assistant: Overturned

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 Recommended as indicated below. Repair of the rotator cuff is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. However, rotator cuff tears are frequently partial-thickness or smaller full-thickness tears. For partial-thickness rotator cuff tears and small full-thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for three months. The preferred procedure is usually arthroscopic decompression, but the outcomes from open repair are as good or better. Surgery is not indicated for patients with mild symptoms or those who have no limitations of activities. (Ejnisman-Cochrane, 2004) (Grant, 2004) Lesions of the rotator cuff are best thought of as a continuum, from mild inflammation and degeneration to full avulsions.

Decision rationale: This patient presents with right shoulder pain. The treater has asked for assistant surgeon on 3/7/14 for a planned right shoulder arthroscopy, subacromial decompression, debridement versus repair of rotator cuff. ODG and other guidelines do not specifically discuss assistant surgeon for shoulder arthroscopic surgery. The utilization review letter authorized surgical assistant, denying the current request for assistant surgeon. An assistant maybe a surgeon or a physician assistant or others. The main surgeon should have the an assistant to perform the surgery and this assistant may be another surgeon. Recommendation is that the request is medically necessary.

ice machine rental/purchase modified to seven (7) day post-op rental of cryotherapy unit.: 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 ODG shoulder chapter Continuous-flow cryotherapy Recommended as an option after surgery, but not for nonsurgical treatment. 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; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. Complications related to cryotherapy (i.e, frostbite) are extremely rare but can be devastating. (Hubbard, 2004) (Osbaahr, 2002) (Singh, 2001) See the Knee Chapter for more information and references.

Decision rationale: This patient presents with right shoulder pain. The treater has asked for ice machine rental purchase on 3/7/14 for a planned right shoulder arthroscopy, subacromial decompression, debridement versus repair of rotator cuff. Regarding cryotherapy, ODG allows for short-term post-operative use for 7 days. ODG states that no research shows any additional added benefit for more complicated cryotherapy units over conventional ice bags or packs. In this case, the requested purchase of an ice machine exceeds ODG guidelines, which only allow a week of post-operative cryotherapy. Recommendation is that the request is not medically necessary.

