

<b>Case Number:</b>	CM14-0069648		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	12/08/2010
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	05/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/14/2014

### 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 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 43-year-old male sustained an industrial injury on 12/8/10. The mechanism of injury was not documented. The patient was status post right shoulder subacromial decompression in December 2005, right shoulder SLAP repair in June 2006, right shoulder SLAP and rotator cuff repair on 10/11/07, and right shoulder arthroscopy, rotator cuff repair, and biceps tenodesis with extensive debridement and platelet-rich plasma injection on 12/9/10. The 2/6/14 right shoulder MR arthrogram impression documented a complete tear of the supraspinatus tendon, retracted centrally with a large gap and reduction of the acromiohumeral distance. There was mild subscapularis tearing, a partial infraspinatus tear, and an attenuated labrum. The humeral head articular cartilage was somewhat thinned and attenuated. There was some loss of the articular cartilage on the superior aspect of the glenoid and superior medial aspect of the humeral head. Findings included chronic synovitis, acromioclavicular (AC) arthritis, intact biceps, osseous fragments above the retracted supraspinatus tendon, and subscapularis tendinitis. The 3/26/14 orthopedic report cited constant severe right shoulder pain. Physical exam findings documented documented positive impingement testing, right shoulder weakness, and no AC joint tenderness. Right shoulder range of motion testing demonstrated active forward flexion and abduction 120 degrees with passive flexion 140 degrees. X-ray findings documented a prominent subacromial spur and moderate AC arthritis. There was some hypertrophic bone at the greater tuberosity. There was an osteophyte on the right humeral head with a slightly reduced acromiohumeral interval of approximately 7 mm. There was an erosion just lateral to the aspect of the articular surface of the humeral head, a flattened acromion, and no os acromiale. Aspiration and corticosteroid injection were performed to the right shoulder. The patient had Lyme disease. The 4/30/14 orthopedic report indicated there was no evidence of right shoulder infection. The patient had severe on-going pain. A reverse shoulder replacement was not recommended because of his

age. A right shoulder humeral resurfacing hemiarthroplasty was recommended. Additional surgical-related requests were submitted. Pain management in the future would be required as the orthopedic surgeon would not provide narcotic pain medications beyond 90 days post surgery. The 5/9/14 utilization review denied the request for right shoulder surgery as there was insufficient clinical objective test demonstration of the appropriate pathology to support the requested services.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Right shoulder humeral resurfacing hemiarthroplasty: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209.

**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: Shoulder disorders. In: Hegmann KT, editor(s). Occupational medicine practice guidelines. Evaluation and management of common health problems and functional recovery in workers. 3rd ed. Elk Grove Village (IL): American College of Occupational and Environmental Medicine (ACOEM); 2011. p. 1-297.

**Decision rationale:** The California MTUS does not provide criteria for this procedure. The 2011 revised ACOEM shoulder guidelines recommend shoulder hemiarthroplasty for moderate to severe arthritides. Humeral resurfacing is recommended as an option. Guideline criteria have been met. This patient presents with irreparable rotator cuff damage. Therefore, this request is medically necessary.

#### **Biceps Tenodesis: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.odgtwc.com/odgtwc/shoulder.htm#surgery>.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Biceps tenodesis Other Medical Treatment Guideline or Medical Evidence: American Academy of Orthopaedic Surgeons (AAOS). American Academy of Orthopaedic Surgeons clinical practice guideline on the treatment of glenohumeral joint osteoarthritis. Rosemont (IL): American Academy of Orthopaedic Surgeons (AAOS); 2009 Dec 4. 198 p.

**Decision rationale:** The California MTUS does not provide recommendations for biceps tenodesis with shoulder hemiarthroplasty. The Official Disability Guidelines support the use of

biceps tenodesis as part of a larger shoulder surgery. The American College of Orthopaedic Surgeons indicated that biceps tenotomy or tenodesis was an option when performing shoulder arthroplasty in patients with glenohumeral joint osteoarthritis. Guideline criteria have been met. Occult biceps tears, incomplete and MRI-negative are often confirmed at the time of surgery. Therefore, this request is medically necessary.

**Possible hospital stay (x 23 hours):** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG hospital length of stay (LOS) guidelines: Total shoulder.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Hospital length of stay (LOS).

**Decision rationale:** The California MTUS does not provide hospital length of stay recommendations. The Official Disability Guidelines recommend the median length of stay (LOS) based on type of surgery, or best practice target LOS for cases with no complications. The recommended median and best practice target total or partial arthroplasty is 2 days and revision arthroplasty is 1 day. The request for possible hospital stay for 23 hours is within guidelines recommendations. Therefore, this request is medically necessary.

**Pre-op medical clearance, H & P:** 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 Other Medical Treatment Guideline or Medical Evidence: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38.

**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. This patient has a past medical history positive for Lyme disease and hypertension. Given these clinical indications, this request for pre-operative clearance with history and physical is medically necessary.

**Labs (unspecified):** Upheld

**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 Other Medical Treatment Guideline or Medical Evidence: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38.

**Decision rationale:** The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. Guidelines criteria have not been met. Although basic lab testing is typically supported for patients undergoing general anesthesia, the medical necessity of a non-specific request cannot be established. Therefore, this request is not medically necessary.

**EKG:** 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 Other Medical Treatment Guideline or Medical Evidence: Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38.

**Decision rationale:** The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines state that an EKG may be indicated for patients with known cardiovascular risk factors or for patients with risk factors identified in the course of a pre-anesthesia evaluation. Guideline criteria have been met. Males over the age of 40 with hypertension have known occult increased cardiovascular risk factor to support the medical necessity of a pre-procedure EKG. Therefore, this request is medically necessary.

**Cold therapy unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.odg-twc.com>.

**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. 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 use of a cold therapy unit would be reasonable for 7 days post-operatively. However, this request is for an unknown length of use which is not consistent with guidelines. Therefore, this request is not medically necessary.

**Assistant surgeon:** 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 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 Code 23470, there is a "2" in the assistant surgeon column. Therefore, based on the stated guideline and the complexity of the procedure, this request is medically necessary.

**Post-op PT (unspecified):** 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 shoulder arthroplasty suggest a general course of 24 post-operative visits over 10 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. Post-operative physical therapy for this patient would be reasonable within the MTUS recommendations. However, this request is for an unknown amount of treatment which is not consistent with guidelines. Therefore, this request is not medically necessary.

**Pain management referral:** Upheld

**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 American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and Consultations, page(s) 127.

**Decision rationale:** The California MTUS guidelines support referral to a specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for treatment of a patient. Guideline criteria have not been met for pain management referral at this time. This request is for possible future referral as the surgeon will only prescribe narcotic pain medications for 90 days after surgery. This medical necessity of this future request is not currently established. Therefore, this request is not medically necessary.