

Case Number:	CM14-0076605		
Date Assigned:	07/18/2014	Date of Injury:	12/15/2009
Decision Date:	09/08/2014	UR Denial Date:	05/05/2014
Priority:	Standard	Application Received:	05/27/2014

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 54-year-old male lineman sustained an industrial injury on 12/15/09. The mechanism of injury was not documented. The 8/16/13 left shoulder MR arthrogram impression documented an approximate 1.1 cm articular surface tear of the lateral anterior supraspinatus tendon, lateral infraspinatus tendinosis adjacent to small cysts of the middle facet, and a tiny paralabral cyst superior anterior labrum, indicative of a tiny occult labral tear. Records indicated that the patient presented on 12/9/13 with a history of intermittent left shoulder symptoms that had become markedly more painful over the past several months. There were marked functional limitations. The patient had a long standing injury and had failed conservative management. The 1/23/14 chart note indicated the patient had on-going pain with decreased range of motion and strength. Surgery was recommended. The provider opined that cortisone would only weaken the tissue and supraspinatus tear. The patient was unable to use his left arm for work. The 3/10/14 chart note indicated the patient was worse with progressive symptoms. He had pain now without activity and at night. He had limited range of motion due to pain. He was unable to sleep. The 4/22/14 treating physician progress report cited continued left shoulder pain with no change in symptoms. Physical exam documented full passive range of motion, diminished active range of motion, diminished rotator cuff power, and positive impingement, relocation and apprehension signs. Prior treatment included medications and activity restrictions. The 5/5/14 utilization review denied the left shoulder arthroscopy and associated requested as there was no detailed documentation of conservative treatment consistent with guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopy, Rotator Cuff Repair: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 9: Page: 209-211; Official Disability Guidelines (ODG) (Shoulder Chapter: Surgery for Impingement Syndrome).

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 show 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 met. This patient presents with a nearly 5 year old injury that progressively worsened over the past 6 months. He has pain at rest and at night that interferes with sleep. There is significant functional limitation precluding full duty work. Physical exam findings were consistent with MRI findings of a partial thickness supraspinatus tear. Reasonable conservative treatment has been tried and failed. Therefore, this request is medically necessary.

Surgery Assistant: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American Association of Orthopaedic Surgeons Position Statement Reimbursement of the First Assistant at Surgery In Orthopaedics.

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 29821, there is a "2" in the assistant surgeon column. Therefore, based on the stated guideline and the complexity of the procedure, this request for is medically necessary.

PT (Physical Therapy) 2 X 6 visits: Overturned

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 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. Twelve initial post-op physical therapy visits are consistent with guidelines. Therefore, this request is medically necessary.

Sling: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder Chapter: Immobilization.

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. Guideline criteria have been met. The use of a post-operative sling is generally indicated. Therefore, this request is medically necessary.

Pre-operative labs and EKG (electrocardiogram): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice Advisory for Preanesthesia Evaluation: A Report by the American Society of Anesthesiologists Task Force On Pre-anesthesia Evaluation.

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. 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 not been met. A generic request for non-specific pre-operative labs and EKG is under consideration. There is no documentation in the file relative to the type of lab testing intended or specific indications that would support any laboratory tests for this patient. In the absence of this information, medical necessity cannot be established. Therefore, this request is not medically necessary.