

Case Number:	CM15-0103436		
Date Assigned:	06/05/2015	Date of Injury:	02/06/2015
Decision Date:	07/09/2015	UR Denial Date:	05/04/2015
Priority:	Standard	Application Received:	05/29/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 injured worker is a 64-year-old male who sustained an industrial injury on 2/6/15. Injury occurred relative to moving heavy ground material while working as a gardener. Past medical history was positive for diabetes mellitus. He reported significant left shoulder pain, inability to lift the arm overhead, and weakness. Conservative treatment included anti-inflammatory medications, analgesic medication, physical therapy, ice, and modified work. The 3/11/15 left shoulder MRI impression documented moderate supraspinatus tendinosis with probable full thickness tear involving the anterior margin at the insertion, and moderate infraspinatus tendinosis without evidence of a tear. There was a SLAP tear involving the superior labrum with extension into the biceps anchor. There were mild osteoarthritic changes involving the acromioclavicular (AC) joint. The 4/21/15 initial orthopedic report cited constant left anterolateral shoulder pain, worsening when he attempted to elevate the arm. He had difficulty performing activities of daily living and therapy had not helped. Physical exam documented left shoulder range of motion as flexion 90, abduction 60, external rotation 70, and internal rotation 60 degrees. There was 2/5 abduction and external rotation strength on the left, compared to 5/5 right. There was mild tenderness over the AC joint and mildly positive impingement signs. X-rays showed a type II acromion on the outlet view with AC joint degenerative changes. The injured worker had sustained a rotator cuff tear and remained symptomatic despite medications, therapy, and activity restrictions. There was significant loss of range of motion and strength that correlated with imaging findings of a full thickness supraspinatus tendon tear. Authorization was requested for left shoulder arthroscopy with subacromial decompression, distal clavicle

excision, rotator cuff repair, and possible biceps tenodesis, assistant surgeon, VascuTherm/cold therapy unit for 28 day rental, and post-operative physical therapy 2x4. The 5/4/15 utilization review non-certified the left shoulder arthroscopy with subacromial decompression, distal clavicle excision, rotator cuff repair, and possible biceps tenodesis, and associated surgical requests as conservative treatment had not been carried out for a last 3-6 months and there was no evidence of a corticosteroid injection. The 6/2/15 orthopedic surgeon appeal letter indicated that the injured worker had worsening left shoulder pain and had not been able to return to work. Medication were not fully relieving his symptoms. Left shoulder range of motion was documented as flexion 70, abduction 50, external rotation 70, and internal rotation 50 degrees. There was 2/5 abduction and external rotation weakness with mild AC joint tenderness and positive impingement signs. The injured worker had a left shoulder rotator cuff repair. There was no reason to believe that performing a corticosteroid injection was going to heal the rotator cuff tear. He had conservative treatment including medications and therapy and his symptoms had progressively worsened. His injury was now 4 months old and there was significant loss of strength and motion. Appeal of the rotator cuff repair with adjunctive subacromial decompression and distal clavicle excision was requested. Further delay will promote possible atrophy of the rotator cuff musculature.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy with subacromial depression, distal clavicle excision, rotator cuff repair with possible biceps tenodesis: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 211, 214.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for rotator cuff repair; Surgery for impingement syndrome; Surgery for SLAP repair, and Partial claviclectomy.

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 shown 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. The Official Disability Guidelines (ODG) provide indications for impingement syndrome that include 3 to 6 months of conservative treatment directed toward gaining full range of motion, which requires both stretching and strengthening. Criteria additionally include subjective clinical findings of painful active arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, tenderness over the rotator cuff or anterior acromial area, positive impingement sign with a positive diagnostic injection test, and imaging showing positive evidence of impingement. Criteria for partial claviclectomy generally require 6 weeks of directed conservative treatment, subjective and objective clinical findings of

acromioclavicular (AC) joint pain, and imaging findings of AC joint degenerative joint disease. The ODG recommend surgery for SLAP lesions after 3 months of conservative treatment, and when history, physical exam, and imaging indicate pathology. SLAP surgery is recommended for patients under age 50, otherwise biceps tenodesis is recommended. Guidelines state definitive diagnosis of SLAP lesions is diagnostic arthroscopy. Guideline criteria have been met. This injured worker presents with persistent left shoulder pain and functional disability. Clinical exam findings are consistent with imaging evidence of rotator cuff tear, plausible impingement, and SLAP tear. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. The injured worker has not undergone a corticosteroid injection but this would be potentially contraindicated in view of his diabetes. Therefore, this request is medically necessary.

Associated surgical service: assistant surgeon: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://files.medical.ca.gov/pubsdoco/publications/masters-mtp/part2/surgmuscu_m01o03.doc; <http://www.fchp.org/NR/rdonlyres/9FD61BA7-29B5-4350-A3F0-29B8FE5C2865/0/Assistantsurgeonpaymentpolicy.pdf>; http://www.bcbsnc.com/assets/services/public/pdfs/medicalpolicy/co-surgeon_assitant_surgeon_and_assistant_at_surgery_guidelines.pdf.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare and Medicaid services, Physician Fee Schedule: Assistant Surgeons, <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>.

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 codes 29826, 29827, 29824, there is a "2" in the assistant surgeon column for each code. Therefore, based on the stated guideline and the complexity of the procedure, this request is medically necessary.

Associated surgical service: vascutherm/cold therapy unit, 28 day rental for left shoulder: 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), Shoulder Chapter (Online version).

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 for 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 28-day rental is not consistent with guidelines, and there is no compelling rationale presented to support an exception to guidelines. Therefore, this request is not medically necessary.

Post operative physical therapy 2 times a week for 4 weeks for left shoulder: 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 impingement syndrome 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. This is the initial request for post-operative physical therapy and is consistent with guidelines. Therefore, this request is medically necessary.