

<b>Case Number:</b>	CM15-0138969		
<b>Date Assigned:</b>	07/28/2015	<b>Date of Injury:</b>	02/14/2013
<b>Decision Date:</b>	09/17/2015	<b>UR Denial Date:</b>	07/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/17/2015

### 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: Montana, Oregon, Idaho  
 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 53 year old male, who sustained an industrial injury on 02/14/2013. He has reported injury to the left shoulder and bilateral knees. The diagnoses have included left shoulder rotator cuff tear; and status post left total knee replacement. Treatment to date has included medications, diagnostics, surgical intervention, physical therapy, and home exercise program. Medications have included Tylenol No. 3. A progress note from the treating physician, dated 04/27/2015, documented an evaluation with the injured worker. The injured worker reported bilateral shoulder pain; he has pain lying on either side; he has limited range of motion, particularly on the left with stiffness; and the left shoulder pain limits his ability to perform many activities. Objective findings included tenderness to the right shoulder in the suprascapular area and anterior shoulder; tenderness to the left shoulder in the subacromial, anterior, and biceps areas; decreased ranges of the bilateral shoulders, worse on the left; muscle strength is decreased at the left shoulder supraspinatus at 4/5 and external rotation at 5-/5; Jamar grip strength had decreased measurements on the left; impingement sign and painful arc tests were positive in the left shoulder; and sensation is intact to the bilateral shoulders. The treatment plan has included the request for left shoulder arthroscopy with rotator cuff repair; associated surgical services: assistant surgeon; Norco 10/325mg #30; associated surgical services: post-operative physical therapy to the left shoulder 12 visits; associated surgical service: sling; and associated surgical services: cold therapy unit rental (7 days).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder arthroscopy with rotator cuff repair: 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), Indications for surgery, rotator cuff repair.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, pages 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. In addition, the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. The ODG Shoulder section, surgery for rotator cuff repair, recommends 3-6 months of conservative care with a painful arc on exam from 90-130 degrees and night pain. There also must be weak or absent abduction with tenderness and impingement signs on exam. Finally, there must be evidence of temporary relief from anesthetic pain injection and imaging evidence of deficit in rotator cuff. In this case the submitted notes from 4/27/15 do not demonstrate 4 months of failure of activity modification. The note from 4/27/15 does not demonstrate the presence of night pain or relief from anesthetic injection. There is no official MRI report available for review which demonstrates a lesion amenable to surgery. Therefore, the requested procedure is not medically necessary.

**Associated surgical services: Assistant surgeon: Upheld**

**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 1. <http://www.aaos.org/about/papers/position/1120.asp>.

**Decision rationale:** CA MTUS/ACOEM/ODG are silent on the issue of assistant surgeon. According to the American College of Surgeons: "The first assistant to the surgeon during a surgical operation should be a trained individual capable of participating and actively assisting the surgeon to establish a good working team. The first assistant provides aid in exposure, hemostasis, and other technical function which will help the surgeon carry out a safe operation and optimal results for the patient. The role will vary considerably with the surgical operation, specialty area, and type of hospital." There is no indication for an assistant surgeon for a routine rotator cuff repair. The guidelines state that "the more complex or risky the operation, the more highly trained the first assistant should be." In addition, the requested medical procedure is not medically necessary and therefore the associated surgical services are not medically necessary.

**Norco 10/325mg #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 80.

**Decision rationale:** According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 80, opioids should be continued if the patient has returned to work and the patient has improved functioning and pain. In this case, the request is for post operative pain control. While opioids may be useful in the short term for treatment of postoperative pain, in this case, the surgical procedure is not medically necessary and the fore the associated surgical services are not medically necessary.

**Post-operative physical therapy to the left shoulder 12 visits:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26-27.

**Decision rationale:** Per the CA MTUS Post-Surgical Treatment Guidelines, Shoulder, pages 26-27 the recommended amount of postsurgical treatment visits allowable are: Complete rupture of rotator cuff (ICD9 727.61; 727.6): Postsurgical treatment: 40 visits over 16 weeks; Postsurgical physical medicine treatment period: 6 months; The requested medical procedure is not medically necessary and therefore the associated surgical services are not medically necessary.

**Associated surgical services: Sling:** 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.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

**Decision rationale:** According to the California MTUS guidelines, Shoulder complaints Chapter 9 pages 212-214, it is recommended to use a brief use of the sling for severe shoulder pain (1-2 days) with pendulum exercises to prevent stiffness and cases of rotator cuff conditions, and prolonged use of the sling only for symptom control is not supported. However, the requested medical procedure is not medically necessary and therefore the associated surgical services are not medically necessary.

**Associated surgical services: Cold therapy unit rental (7 days):** 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, 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.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of shoulder cryotherapy. According to ODG Shoulder Chapter, Continuous flow cryotherapy, it is recommended immediately postoperatively for upwards of 7 days. However, the requested medical procedure is not medically necessary and therefore the associated surgical services are not medically necessary.