

<b>Case Number:</b>	CM15-0034940		
<b>Date Assigned:</b>	04/03/2015	<b>Date of Injury:</b>	12/12/2014
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/24/2015

### 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 49-year-old female who sustained an industrial injury on 12/12/14. Injury occurred when she fell, landing on her right shoulder. Conservative treatment included activity modification, physical therapy, anti-inflammatory medications, and muscle relaxants. A corticosteroid injection was provided on 12/30/14. The 1/21/15 right shoulder MRI impression documented prominent and diffuse supraspinatus tendinopathy with irregular non-retracted full thickness perforation tear along the anterior insertion with mild to moderate muscle belly atrophy. There was prominent biceps tendinopathy through the intrascapular segment. The biceps tendon was subluxed centrally along the superior groove into a partially torn and edematous distal subscapularis. There was mild anterior insertional infraspinatus tendinopathy, and prominent bony reactive changes along the humeral head adjacent to the bicipital groove. There were moderately-advanced acromioclavicular (AC) joint degenerative and hypertrophic changes, including undersurface spurring which effaced the subacromial fat plane. The 2/4/15 initial orthopedic report cited right shoulder pain and limited functional ability. MRI findings showed a small rotator cuff tear and subscapularis tendon tear. Physical exam documented minimal AC joint tenderness, bicipital groove tenderness, and minimal pain with cross-body abduction. Speed's and Yergason's tests were positive. Right shoulder range of motion was flexion 120, abduction 110, external rotation 70 and internal rotation 90 degrees. There was a positive belly press test and lift-off sign. There was weakness and pain in external rotation, and mild weakness in internal rotation, flexion and abduction. The diagnosis was rotator cuff tear right shoulder subscapularis and supraspinatus and biceps subluxation of the bicipital groove.

She had not responded to nearly 2 months of conservative treatment and was not improving with time. Authorization was requested for right rotator cuff repair and biceps tenodesis; an assistant surgeon; pre-operative clearance; 16 post-operative physical therapy sessions for the right shoulder; seven-day rental of a cold therapy unit; shoulder slingshot, and continuous passive motion (CPM) unit for the right shoulder for treatment of the right shoulder rotator cuff and subscapularis tendon tears. The 2/13/15 utilization review non-certified the request for right shoulder surgery and associated requests based on an absence of 3 months of conservative treatment trial and failure.

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

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

#### **Rotator cuff repair of right shoulder and biceps tenodesis: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation ODG- Shoulder (web: updated 10/31/14), Indications for surgery-rotator cuff repair.

**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; Biceps tenodesis.

**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 for rotator cuff repair with a diagnosis of full thickness tear typically require clinical findings of shoulder pain and inability to elevate the arm, weakness with abduction testing, atrophy of shoulder musculature, usually full passive range of motion, and positive imaging evidence of rotator cuff deficit. The ODG state that consideration of biceps tenodesis should include evidence of an incomplete tear with associated subjective/objective clinical findings, and is supported with concomitant rotator cuff repair. Guideline criteria have been met. This patient presents with persistent function-limiting right shoulder pain. Clinical exam findings are consistent with imaging evidence of a full thickness supraspinatus tear with atrophy, partial biceps tendon tear with subluxation, and impingement. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, including physical therapy, medications and injection, and failure has been submitted. Therefore, this request is medically necessary.

#### **Pre-op clearance: 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 Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

**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. Middle-aged females have known occult increased medical/cardiac risk factors. Given these clinical indications, this request is 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 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 code 29827, 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.

**16 postop physical therapy sessions for the right shoulder:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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/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. Although this

request exceeds recommendations for initial care, it is consistent with the recommended general course. Therefore, this request is medically necessary.

**Associated surgical services: Cold therapy rental x 7 days:** 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 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. Guideline criteria have been met. Therefore, this request is medically necessary.

**Associated surgical services: Shoulder slingshot:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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. Slings are recommended as an option for patients with acromioclavicular separations or severe sprains. Prolonged use of a sling only for symptom control is not recommended. Guideline criteria have been met. The use of a post-operative sling is generally indicated. Therefore, this request is medically necessary.

**Associated surgical services: Shoulder continuous passive motion:** 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 Official Disability Guidelines (ODG) Shoulder: Continuous passive motion (CPM).

**Decision rationale:** The California MTUS does not provide recommendations for continuous passive motion (CPM) following shoulder surgery. The Official Disability Guidelines state that CPM is not recommended for shoulder rotator cuff problems or after shoulder surgery, except in cases of adhesive capsulitis. Guideline criteria have not been met. There is no current evidence that this patient has adhesive capsulitis. Prophylactic use of continuous passive motion in

shoulder surgeries is not consistent with guidelines. Therefore, this request is not medically necessary.