

<b>Case Number:</b>	CM15-0089785		
<b>Date Assigned:</b>	05/14/2015	<b>Date of Injury:</b>	01/30/2014
<b>Decision Date:</b>	06/15/2015	<b>UR Denial Date:</b>	04/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/11/2015

### 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: California, Indiana, Oregon  
 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:

This 27 year old male sustained an industrial injury to the right shoulder on 1/30/14. Previous treatment included magnetic resonance imaging, eight physical therapy sessions, one cortisone injection and medications. In an orthopedic evaluation dated 4/15/15, the injured worker complained of pain 8/10 on the visual analog scale to the right shoulder that worsened with activity. The injured worker reported clicking, catching, lock and weakness. The injured worker reported that his symptoms were not changing. Physical exam was remarkable for full range of motion to bilateral shoulders with 5/5 strength, pain to palpation in the right bicipital groove with significantly positive O'Brien's and positive Hawkin's maneuver. The physician noted that magnetic resonance imaging arthrogram (7/1/14) showed a superior labral anterior posterior (SLAP) tear with thickening of the supraspinatus tendon. Current diagnoses included right shoulder likely SLAP tear and impingement syndrome. The treatment plan included arthroscopic SLAP repair with decompression and associated surgical services.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MD as surgical assist:** 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), Low Back, Surgical assistant.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of a surgical assistant. ODG low back is referenced. More complex cases based off CPT code are felt to warrant the use of a surgical assistant. The requested procedure is arthroscopic SLAP repair. Given the level of complexity of the surgery, it is not felt to be medically necessary to have an assistant.

**Purchase of a post operative cold therapy unit:** 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. DME is considered to be reusable and retail is preferred. In this case, the request is for purchase and is therefore not medically necessary.

**Post-operative abduction sling for the right 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, Postoperative abduction pillow sling.

**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 abduction pillow. Per the ODG criteria, abduction pillow is recommended following open repair of large rotator cuff tears but not for arthroscopic repairs. In this case, there is no indication for need for open rotator cuff repair and therefore determination is not medically necessary.