

Case Number:	CM14-0165671		
Date Assigned:	10/09/2014	Date of Injury:	01/19/2012
Decision Date:	12/17/2014	UR Denial Date:	09/15/2014
Priority:	Standard	Application Received:	10/06/2014

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 32-year-old male sustained an industrial injury on 1/19/12. The mechanism of injury was not documented. The 2/24/12 left shoulder MRI impression documented minimal edema within the distal supraspinatus tendon, indicative of minimal tendinosis with no evidence of a tendon tear or retraction. There was mild acromioclavicular (AC) osteoarthritis with hypertrophic changes and small osteophyte formation with slight downsloping of the lateral acromion. Records indicated the patient had completed an extensive course of physical therapy with activity modification, anti-inflammatory and pain medications, and subacromial corticosteroid injections without sustained improvement. Significant functional limitation was noted in reaching and overhead activities. The 8/27/14 treating physician progress report cited 5 days of relief with a recent subacromial injection, followed by return of left shoulder pain. The patient was reported miserable with tenderness over the AC joint and anterolateral shoulder with significant spasms. Left shoulder range of motion was 160 degrees forward flexion and 150 degrees abduction. Impingement testing was positive. The diagnosis was left shoulder grade I/II AC separation with impingement syndrome and trapezial myofascial pain. The treatment plan recommended left shoulder arthroscopy with subacromial decompression and full Mumford procedure. The 9/15/14 utilization review approved the request for left shoulder arthroscopy, subacromial decompression, and Mumford procedure with 12 post-op physical therapy visits and Vicodin 5/300 mg #60. The request for rental/purchase of a cold therapy unit was modified and approved for a 7-day rental consistent with guidelines. The request for an Ultrasling was modified and approved for a standard sling. The request for a co-surgeon was denied as this was a fairly uncomplicated surgery and would not require a surgeon over a surgical technician or surgical RN. The request for post-op medication, OxyContin 20 mg BID #20, was denied as

there was no indication that post-op Vicodin would provide inadequate pain control requiring the addition of a second opioid.

IMR ISSUES, DECISIONS AND RATIONALES

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

Co-Surgeon: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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 co-surgeons. The Center for Medicare and Medicaid Services (CMS) provide direction relative to the typical medical necessity of co-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 co-surgeon heading imply that a co-surgeon is not necessary; however, procedure codes with a 1 or 2 implies that a co-surgeon is usually necessary. For this requested surgery, CPT codes 29826 and 29824, there is a "1" in the co-surgeon column for each procedure. Therefore, based on the stated guideline and the complexity of the procedure, this request is medically necessary.

Cold treatment unit rental/purchase: 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, 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, 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. The 9/15/14 utilization review decision recommended partial approval of this cold therapy device for 7-day use. There is no compelling reason in the records reviewed to support the medical necessity of a cold device beyond the 7-day rental recommended by guidelines and previously approved. Therefore, this request is not medically necessary.

Ultrasling: 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), Postoperative abduction pillow sling

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 14 Ankle and Foot Complaints Page(s): 205,213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Postoperative abduction pillow sling

Decision rationale: The California MTUS guidelines state that the shoulder joint can be kept at rest in a sling if indicated. The Official Disability Guidelines state that post-operative abduction pillow slings, are recommended as an option following open repair of large and massive rotator cuff tears. Guideline criteria have not been met. There is no imaging or clinical evidence of a massive rotator cuff tear. A standard sling was approved in utilization review on 9/15/14; there is no compelling reason to support the medically necessary of a specialized abduction sling. Therefore, this request is not medically necessary.

Post-op OxyContin 20mg BID #20: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, OxyContin Page(s): 76-80, 97.

Decision rationale: The California MTUS guidelines indicate that Oxycontin is a controlled release formulation of Oxycodone Hydrochloride indicated for the management of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time. Oxycontin is not indicated for use as an as needed analgesic. Guideline criteria have not been met. There is no indication that this patient would require around-the-clock analgesia for an extended period of time or that the currently certified Vicodin would be insufficient to manage post-operative pain. There is no compelling reason to support the medical necessity of an additional opioid for pain management. Therefore, this request is not medically necessary.