

<b>Case Number:</b>	CM14-0218066		
<b>Date Assigned:</b>	02/11/2015	<b>Date of Injury:</b>	08/23/2013
<b>Decision Date:</b>	03/30/2015	<b>UR Denial Date:</b>	12/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2014

### 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. 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 (IW) is a 52-year-old female who sustained an industrial injury on 08/23/2013 from lifting. The 10/22/13 left shoulder MRI impression documented moderate supraspinatus tendinosis with low back interstitial tearing of the posterior fibers at the footprint, and mild infraspinatus and subscapularis tendinosis. There was no rotator cuff atrophy. There was mild intraarticular long head biceps tendinosis, moderate extra-articular long biceps tendinosis with interstitial tearing and mild tenosynovitis. There was no definite full thickness biceps tendon rupture. There was mild acromioclavicular joint arthrosis and a type II acromion. In the visit notes of 09/26/2014, conservative treatments to date included oral medications, physical therapy, corticosteroid injection, home exercise program, and use of H wave. The 11/7/14 treating physician report indicated that the patient was status post right shoulder subacromial decompression, debridement and rotator cuff repair. She reported left shoulder pain 5/10, localized to the subacromial region, and aggravated with overhead activities. Left shoulder range of motion documented flexion and abduction 120-degrees with positive Hawkin's, Yergason's, Speed's, and O'Brien's tests. She was non-tender to palpation over the acromioclavicular joint. The diagnoses included partial thickness rotator cuff tear, subacromial impingement syndrome, rule-out partial tear left biceps tendon, and adhesive capsulitis. The patient had exhausted conservative treatment for the left shoulder, including physical therapy and injections. The treatment plan requested left shoulder arthroscopy and debridement, rotator cuff repair as needed, and biceps tenodesis as needed. Requests for pre-op lab work, post-op physical therapy and a surgical assistant and a pre-op EKG were also made. On 12/10/2014 utilization

review non-certified requests for left shoulder arthroscopy with biceps tenodesis, debridement, rotator cuff repair, and subacromial decompression, along with the associated surgical requests: initial post-op physical therapy, two times weekly for the left shoulder, pre-op EKG, pre-op lab work, and surgical assistant. Non-certification was based on evidence that the patient was 6 weeks status post left shoulder arthroscopy with a decompression and there had been insufficient post-op time for rehabilitation, oral and injectable medications, in the absence of a new injury. The MTUS, ACOEM Guidelines, (or ODG) were cited. The 11/20/14 treating physician appeal letter indicated that there was a transcription error in his 11/7/14 report that indicated that the patient was 6 weeks status post left shoulder surgery. It should have indicated that the patient was 6 weeks status post left shoulder subacromial injection with initial good improvement but the pain had returned. Appeal for the left shoulder surgery was requested.

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

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

**Surgical assistant per 12/03/14 form:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines(ODG)

**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 28287, 29822, and 29826, 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.

**Left shoulder arthroscopy with subacromial decompression:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines(ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Shoulder: Surgery for impingement syndrome

**Decision rationale:** The California MTUS guidelines provide a general recommendation for impingement surgery. Conservative care, including steroid injections, is recommended for 3-6

months prior to surgery. The Official Disability Guidelines provide more specific indications for impingement syndrome and acromioplasty 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, and positive impingement sign with a positive diagnostic injection test. Imaging clinical findings showing positive evidence of impingement are required. Guideline criteria have been met. This patient presents with persistent function-limiting left shoulder pain. Clinical exam findings are consistent with imaging evidence of partial thickness rotator cuff tear and plausible impingement. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

**Left shoulder arthroscopy with debridement:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines(ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Shoulder: Surgery for rotator cuff repair.

**Decision rationale:** The California MTUS guidelines provide general recommendations for rotator cuff repair and impingement syndrome. For rotator cuff tears presenting primarily as impingement, surgery is reserved for cases failing conservative treatment for three months. The Official Disability Guidelines for rotator cuff repair of partial thickness tears require 3 to 6 months of conservative treatment plus weak or absent abduction and positive impingement sign with a positive diagnostic injection test. Guideline criteria have been met. This patient presents with persistent function-limiting left shoulder pain. Clinical exam findings are consistent with imaging evidence of partial thickness rotator cuff tear. Positive impingement testing and diagnostic injection test have been documented. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary

**Left shoulder arthroscopy with rotator cuff repair:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines(ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Shoulder: Surgery for rotator cuff repair.

**Decision rationale:** The California MTUS guidelines provide general recommendations for rotator cuff repair and impingement syndrome. For rotator cuff tears presenting primarily as impingement, surgery is reserved for cases failing conservative treatment for three months. The

Official Disability Guidelines for rotator cuff repair of partial thickness tears require 3 to 6 months of conservative treatment plus weak or absent abduction and positive impingement sign with a positive diagnostic injection test. Guideline criteria have been met. This patient presents with persistent function-limiting left shoulder pain. Clinical exam findings are consistent with imaging evidence of partial thickness rotator cuff tear. Positive impingement testing and diagnostic injection test have been documented. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

**Left shoulder arthroscopy with biceps tenodesis:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines(ODG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder: Biceps tenodesis

**Decision rationale:** The California MTUS guidelines do not provide specific recommendations for biceps tenodesis. The Official Disability Guidelines state that consideration of biceps tenodesis after 3 months of conservative treatment for patients undergoing concomitant rotator cuff repairs. Guideline criteria have been met. This patient presents with persistent function-limiting left shoulder pain. Clinical exam findings are consistent with imaging evidence of a biceps pathology. This patient is undergoing a concomitant rotator cuff repair. Occult biceps tears, incomplete and MRI-negative are often confirmed at time of arthroscopic surgery. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

**Initial post-op physical therapy, two times weekly for the left shoulder:** Upheld

**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 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. Post-operative physical therapy for this patient would be reasonable within the MTUS recommendations. However, this request is for an unknown amount of treatment which is not consistent with guidelines. Therefore, this request for an unknown amount of post-operative physical therapy visits is not medically necessary.

**Pre-op EKG:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines(ODG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3):522-38

**Decision rationale:** The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines state that an EKG may be indicated for patients with known cardiovascular risk factors or for patients with risk factors identified in the course of a pre-anesthesia evaluation. Guideline criteria have been met. Middle-aged females have known occult increased cardiovascular risk factor to support the medical necessity of a pre-procedure EKG. Therefore, this request for is medically necessary.

**Pre-op lab work:** 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)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology 2012 Mar; 116(3):522-38

**Decision rationale:** The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. Although basic lab testing is typically supported for patients undergoing general anesthesia, the medical necessity of a non-specific request cannot be established. Therefore, this request is not medically necessary.

**Pre-op lab work:** 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)

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for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. Although basic lab testing is typically supported for patients undergoing general anesthesia, the medical necessity of a non-specific request cannot be established. Therefore, this request is not medically necessary.