**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 60-year-old female, who sustained an industrial injury on 2/11/14 relative to repetitive motion. Past medical history was positive for rheumatoid arthritis. Past surgical history was positive for prior arthroscopic shoulder surgery, details unknown. Conservative treatment included 6 visits of physical therapy, activity, modification, anti-inflammatory medications, and 2 corticosteroid injections to the right shoulder without sustained benefit. The 11/20/14 right shoulder MRI impression documented mild hypertrophic and degenerative changes of the acromioclavicular (AC) joint with slight narrowing of the subacromial which may contribute to impingement. There was distal supraspinatus and subscapularis tendinosis. The 12/4/14 treating physician report continued pain and stiffness in the right shoulder; no changes in symptoms. Right shoulder exam documented close to full range of motion, positive impingement signs, and decreased rotator cuff strength. The recent MRI showed active inflammation of the rotator cuff with no full thickness tear. She had failed conservative measures and continued to have pain. The treatment plan recommended right shoulder arthroscopy with subacromial decompression. Authorization was requested for: Right shoulder arthroscopy; right shoulder subacromial decompression (SAD); surgical assistant PA-C or RN; pre-op labs: CBC, BMP, EKG; Norco 5/325 mg #75; post-op physical therapy (PT) 2 x 6 (12 sessions); and post-op sling. On 12/23/2014 Utilization Review noncertified a prescription of right shoulder arthroscopy with subacromial decompression and associated surgical services citing an absence of documented conservative treatment trial and failure for at least 3 to 6
months. The MTUS, ACOEM and ODG were cited. On 01/20/2015, the injured worker submitted an IMR application.

**IMR ISSUES, DECISIONS AND RATIONALES**

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

**Right shoulder arthroscopy:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

**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. Guideline criteria have been met. This patient presents with persistent function-limiting right shoulder pain and stiffness, precluding work ability. Clinical exam evidence and imaging findings are consistent with 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.

**Right shoulder subacromial decompression (SAD):** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204, 211, 214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter - Surgery for impingement syndrome; Indications for Surgery - Acromioplasty

**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 right shoulder pain and stiffness, precluding work ability. Clinical exam evidence and imaging findings are consistent with 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.

**Associated surgical service: surgical assistant, PA-C or RN:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Milliman Care Guidelines, 12th addition

**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 29822, 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.

**Associated surgical service: pre-op labs: CBS, BMP, EKG:** Overturned

**Claims Administrator guideline:** The Claims Administrator 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. (26 references)

**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. 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 medical/cardiac risk factors. Given these clinical indications and the risks of anesthesia, this request is medically necessary.

**Norco 5/325mg #75:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone (Vicodin, Lortab).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Hydrocodone/acetaminophen, Page(s): 76-80, 91.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines support the use of opioids on a short term basis for wrist/hand pain. Guidelines recommend Norco for moderate to moderately severe pain on an as needed basis with a maximum dose of 8 tablets per day. Short-acting opioids, also known as normal-release or immediate-release opioids, are seen as an effective method in controlling both acute and chronic pain. Guideline criteria have been met for the post-operative use of Norco. Therefore, this request is medically necessary.

**Post-op physical therapy 2 x 6 (12 sessions):** Overturned

**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 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 post surgical physical medicine period. This initial post-operative physical therapy visits are within guideline recommendations. Therefore, this request is medically necessary.

**Post-op sling:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines; Immobilization; postoperative abduction pillow sling

**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 and recommend slings as an option for patients with rotator cuff tears.
Guideline criteria have been met. The use of a post-operative sling is generally indicated. Therefore, this request is medically necessary.