

Case Number:	CM15-0110190		
Date Assigned:	06/16/2015	Date of Injury:	02/11/2015
Decision Date:	08/18/2015	UR Denial Date:	05/05/2015
Priority:	Standard	Application Received:	06/08/2015

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:

This injured worker is a 32-year-old male who sustained an industrial injury on 2/11/15. Injury occurred when he was working on a ladder pulling boxes overhead. He pulled a 50-pound box with his right shoulder hyper extended and felt a pop with immediate onset of pain. Conservative treatment included pain and anti-inflammatory medications, physical therapy with limited benefit, and work/activity modification. The 3/24/15 right shoulder MRI impression documented inflammation and cystic resorption of bone at the acromioclavicular (AC) joint, rotator cuff strain, SLAP tear with synovitis and loculated fluid in the rotator interval and in the subscapularis recess of the joint, and glenohumeral capsulitis. Findings documented a tear of the biceps labral anchor from the 12 to 10 o'clock position posteriorly. The proximal most fibers of the biceps were split coming into the anchor. The acromion was curved with slight lateral down slope and moderate narrowing of the lateral aspect of the subacromial outlet. The 5/1/15 orthopedic report cited continued grade 4/10 right shoulder pain. He continued to work with discomfort. Physical exam documented significant tenderness and pain in the anterior aspect of the right shoulder. He had positive circumduction, Speed's, O'Brien's, and Neer and Hawkin's impingement tests. Right shoulder range of motion was full. The diagnosis was right shoulder SLAP tear and bursitis. Treatment options were discussed. The injured worker did not want a corticosteroid injection. Authorization was requested for right shoulder arthroscopy, subacromial decompression and possible biceps tenodesis, 12 sessions of post-operative physical therapy, post-operative cold therapy unit rental for 7 days, and an assistant surgeon. The 5/5/15 utilization review non-certified the right shoulder arthroscopy, subacromial decompression and possible

biceps tenodesis and associated surgical requests as there was no evidence that conservative treatment had been exhausted, including a full course of physical therapy and injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy, subacromial decompression and possible biceps tenodesis:

Overtured

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for Impingement syndrome; Surgery for SLAP lesions.

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. Surgery for impingement syndrome is usually arthroscopic decompression. The Official Disability Guidelines (ODG) provide more specific indications for impingement syndrome 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, positive impingement sign with a positive diagnostic injection test, and imaging showing positive evidence of impingement or rotator cuff deficiency. The ODG recommend surgery for SLAP lesions after 3 months of conservative treatment for Type II or IV lesions, when history and physical exam and imaging indicate pathology. Guideline criteria have been met. This injured worker presents with persistent right shoulder pain and difficulty in work duties. History and physical exam and imaging are consistent with a SLAP tear. Clinical exam findings and imaging are also consistent with subacromial impingement. Three months of reasonable conservative treatment, including physical therapy, anti-inflammatory medications, and activity alteration, have failed to improve symptoms. Therefore, this request is medically necessary.

Post-operative physical therapy two times a week for six weeks for the right shoulder quantity: 12: Overtured

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. If it is determined 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 request for physical therapy is consistent with guidelines recommendations for initial post-operative treatment. Therefore, this request for is medically necessary.

Post-operative cold therapy unit rental quantity: 7 days: 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), Treatment Index, 13th Edition (Web), 2015, Shoulder section, Criteria for 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. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. This request is consistent with guidelines. Therefore, 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 codes 29826 and 29807, 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.