

Case Number:	CM15-0024583		
Date Assigned:	02/17/2015	Date of Injury:	04/22/2013
Decision Date:	04/01/2015	UR Denial Date:	01/20/2015
Priority:	Standard	Application Received:	02/09/2015

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:

The injured worker is a 45-year-old female who sustained an industrial injury on 4/22/13. Conservative treatment included 24 physical therapy visits, 12 chiropractic visits, 18 acupuncture visits, medications, home exercise program, activity modification, and 3 corticosteroid injections. One corticosteroid injection provided 100% relief for 5 weeks. The 1/7/15 right shoulder MRI impression documented tendinosis with small partial bursal surface tear of the distal supraspinatus tendon without retraction. There was infraspinatus tendinosis and a small undersurface tear, and subscapularis tendinosis without tear. Findings were suggestive of glenoid labral degeneration. There were moderate right acromioclavicular (AC) hypertrophic changes with small inferior osteophytes causing indentation on the supraspinatus muscle and tendon, and may result in impingement. The 1/12/15 treating physician report cited persistent grade 5/10 right upper extremity pain with numbness and tingling of the entire right arm and weakness. Physical exam documented right shoulder elevation 110 degrees, internal rotation to T8, and external rotation 80 degrees. There were positive apprehension, relocation, Neer, Hawkin's, and O'Brien's tests. Rotator cuff strength was 4+/5. There was tenderness over the bicipital groove. Right shoulder x-rays were obtained and showed mild AC arthritis. The diagnosis included shoulder internal derangement. The treating physician requested a right shoulder rotator cuff debridement, possible repair, possible anterior stabilization, post-op physical therapy x 12 sessions, surgical first assist, post-op arm sling, cold therapy unit rental x 7 days, pre-op lab and pre-op EKG. On 1/20/15, utilization review non-certified a request for a right shoulder rotator cuff debridement, possible repair, possible anterior stabilization, post-op physical therapy x 12

sessions, surgical first assist, post-op arm sling, cold therapy unit rental x 7 days, pre-op lab and pre-op EKG. The utilization review physician cited the evidence-based guidelines for the surgery not being medically necessary and subsequent services related to a non-covered service. On 1/27/15, the injured worker submitted an application for IMR. The 1/21/15 treating physician appeal provided a hard copy of the MRI report. Physical exam findings included positive apprehension sign and relocation test, both very sensitive for anterior instability and labral pathology. MRI was often not sensitive for labral pathology. She had signs of impingement consistent with imaging evidence of partial rotator cuff tearing. Exhaustive conservative treatment was documented.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-Operative Arm Sling: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Shoulder, 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. Slings are recommended as an option for patients with acromioclavicular separations or severe sprains. Prolonged use of a sling only for symptom control is not recommended. Guideline criteria have been met. The use of a post-operative sling is generally indicated. Therefore, this request is medically necessary.

Post-Operative Cold Therapy Unit (7-day rental): Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation 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: 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. This request is consistent with guidelines and is medically necessary.

Pre-Operative Labs: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back, Preoperative Lab Testing.

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 for pre-operative labs is not medically necessary.

Surgical First Assist: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back, Surgical Assistant.

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 29287 and 29822, 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.

Right Shoulder Rotator Cuff Debridement , Possible Repair, Possible Anterior Stabilization: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Indications for Surgery, Shoulder Dislocation Surgery.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Surgery for rotator cuff repair; Surgery for impingement syndrome; Surgery for SLAP lesions.

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. The Official Disability Guidelines (ODG) for rotator cuff repair of partial thickness tears generally require 3 to 6 months of conservative treatment, plus painful arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, rotator cuff or anterior acromial tenderness, and positive impingement sign with a positive diagnostic injection test. Criteria include imaging evidence of a rotator cuff deficit. The ODG guidelines state that SLAP lesions may warrant surgical treatment in certain cases and may be considered for patients failing conservative treatment. The ODG recommend surgery for SLAP lesions after 3 months of conservative treatment, and when history, physical exam, and imaging indicate pathology. SLAP surgery is recommended for patients under age 50, otherwise biceps tenodesis is recommended. Guidelines state definitive diagnosis of SLAP lesions is diagnostic arthroscopy. Guideline criteria have been met. This patient presents persistent function-limiting right shoulder pain. There are clinical exam findings consistent with imaging evidence of rotator cuff pathology, possible labral tear, and plausible impingement. Detailed evidence of a recent, exhaustive comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Post-Operative Physical Therapy (12-sessions): Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26-27. Decision based on Non-MTUS Citation ODG Physical Therapy.

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 and 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. This is the initial request for post-operative physical therapy and consistent with guidelines. Therefore, this request is medically necessary.

Pre-Operative EKG: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back, Preoperative Electrocardiogram (EKG).

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 is medically necessary.