

Case Number:	CM15-0093758		
Date Assigned:	05/22/2015	Date of Injury:	06/14/2014
Decision Date:	07/10/2015	UR Denial Date:	04/29/2015
Priority:	Standard	Application Received:	05/15/2015

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 53-year-old male who sustained an industrial injury on 6/14/14. Injury occurred when the patient's head was hit with a branch while driving a tractor. The 2/2/15 left shoulder MRI impression documented osteoarthritis changes of the acromioclavicular (AC) joint with a laterally downsloping acromion process and mild subacromial spurring, placing the injured worker at higher risk for impingement. There were mild osteoarthritic changes of the glenohumeral joint. There was supraspinatus tendinopathy, and a partial thickness articular side tear of the supraspinatus tendon at the insertion involving nearly 50% of its thickness. There was signal alteration of the superior labrum, worrisome for a SLAP lesion, and signal alteration of the inferior glenohumeral height capsule, which might be seen with adhesive capsulitis. The 3/30/15 treating physician report cited left shoulder pain. Physical exam documented left shoulder tenderness and positive impingement signs. X-rays of the left shoulder and humerus showed progressive spurring on the undersurface of the acromion with soft tissue swelling of the proximal humerus. The diagnosis was left shoulder impingement syndrome with significant partial thickness tear of the rotator cuff. The injured worker had exhausted conservative treatment including physical therapy, medications, injections, and rest, and remained disabled. Injections had provided 2 days of mild relief. Authorization was requested for left shoulder arthroscopy with acromioplasty, possible PASTA repair, possible Mumford procedure, and possible biceps tenodesis, with assistant surgeon/PA, anchors and screws for repair, pain pump purchase, cold therapy unit purchase, and IF (interferential) unit for 30-day rental. The 4/22/15 utilization review certified the request for left shoulder arthroscopy with acromioplasty, possible PASTA repair, possible Mumford procedure, and possible biceps tenodesis following discussion with the treating physician. The request for assistant surgeon was non-certified as the

surgeon indicated an assistant was not needed. The request for anchors and screws was non-certified as the surgeon indicated that they would not be needed. The request for pain pump was non-certified as not supported by guidelines. The request for a cold therapy unit purchase was modified to a 7-day rental consistent with the Official Disability Guidelines. The request for an IF unit was non-certified as the medical necessity for this request was not established consistent with guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Anchors and Screws for repair: 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 Wheelless Textbook of Orthopaedics. http://www.wheellessonline.com/ortho/rotator_cuff_repair_techniques Updated 4/9/15.

Decision rationale: The California MTUS and Official Disability Guidelines do not provide recommendations for the use of anchors and screws for shoulder surgery repairs. The Wheelless Textbook of Orthopaedics supports the use of anchors and screws for rotator cuff repair. The use of anchors and screws for the possible repairs should be left to the surgeon's discretion. Therefore, this request is medically necessary.

Assistant Surgeon/ PA: Overturned

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

DME (durable medical equipment): Pain pump 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: Shoulder chapter - Post operative pain pump.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Postoperative pain pump.

Decision rationale: The California MTUS guidelines are silent regarding this device. The Official Disability Guidelines state that post-operative pain pumps are not recommended. Guidelines state there is insufficient evidence to conclude that direct infusion is as effective as or more effective than conventional pre- or postoperative pain control using oral, intramuscular or intravenous measures. Three recent moderate quality randomized controlled trials did not support the use of pain pumps. Given the absence of guideline support for the use of post-operative pain pumps, this request for pain pump purchase is not medically necessary.

DME (durable medical equipment) Cold Therapy Unit, 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: Shoulder chapter - Cold compression therapy.

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 is silent regarding cold therapy units. The Official Disability Guidelines state that continuous-flow cryotherapy is an option for up to 7 days in the post-operative setting following shoulder surgery. The 5/14/15 utilization review decision recommended partial certification of a cryotherapy unit for 7-day rental. There is no compelling reason in the medical records to support the medical necessity of a cold therapy unit beyond the 7-day rental already certified. Therefore, this request is not medically necessary.

DME (durable medical equipment) IF (interferential frequency) unit, 30 day rental:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: The California MTUS guidelines do not recommend interferential current (IFC) stimulation as an isolated intervention. Guidelines indicate that a one-month IFC trial may be indicated for post-operative conditions if there is significant pain that limits the ability to perform exercise programs/physical therapy treatment. Guideline criteria have not been met. There is no indication that the patient will be unable to perform post-op physical therapy exercise or treatment, or that standard post-operative pain management will be ineffective. Therefore, this request is not medically necessary.