

Case Number:	CM14-0148876		
Date Assigned:	09/18/2014	Date of Injury:	05/31/2012
Decision Date:	10/17/2014	UR Denial Date:	08/12/2014
Priority:	Standard	Application Received:	09/12/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Illinois, California and Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 62-year-old male construction worker sustained an industrial injury on 5/31/12. Injury occurred when he lifted a 23-foot long frame from an awkward position. Past surgical history is positive for an aortic valve replacement in 1998 and right shoulder arthroscopy on 1/28/14. Past medical history was positive for a left clavicle fracture in 1982, and long-term Coumadin therapy. The 3/8/13 left shoulder MRI impression documented severe glenohumeral osteoarthritis with chronic degenerative changes involving the labrum, a possible old fracture involving the superior labrum, and a superior labral tear. There was supraspinatus tendinosis without evidence of a full thickness tear with moderate acromioclavicular joint osteoarthritis. There was abnormal bone edema over the proximal humeral diaphysis. Left shoulder x-rays obtained 6/19/13 demonstrated a prior decompression and slight widening in the acromioclavicular joint. Early degenerative changes of the humeral head were reported consistent with moderate degenerative joint disease. The 6/16/14 orthopedic report cited patient concerns over his left shoulder symptoms and functional use. The patient was recovering well from his right shoulder surgery with full range of motion and nearly normal strength. Left shoulder had good range of motion and positive Hawkin's impingement sign. Speed's, O'Brien's, and cross arm tests were negative. The diagnosis was left shoulder symptomatic impingement with SLAP tear. Positive MRI findings were noted including superior labral tear, supraspinatus and subscapularis tendinosis without full thickness tear, and moderate osteoarthritis. The patient had completed a full 3 to 4 month course of physical therapy for both shoulders. His right shoulder was doing quite well post-op. The patient still had symptoms with exercise and use of the left shoulder. His construction job was quite physical and he was concerned about potentially going back to work and getting a lot worse or severely reinjuring himself. The patient desired to proceed with surgery. The 7/28/14 treating physician report cited unchanged left shoulder

complaints with some difficulty in repetitive activities, particularly overhead, some weakness, and anterior lateral pain. Left shoulder exam documented trace tenderness at the rotator cuff insertion and anterior capsule with near full active range of motion, 4/5 rotator cuff strength, and positive Hawkin's impingement sign. The patient was to continue his home exercise program pending surgery. The 8/12/14 utilization review denied the left shoulder surgery and associated requests as the patient had evidence of moderate osteoarthritis, prior subacromial decompression and labral repair were reported, current pathology was likely degenerative, and the condition would not be improved with surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy, Subacromial Decompression, Debridement, and SLAP repair:
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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for impingement syndrome, Surgery for SLAP tears.

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 (ODG) 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. The ODG for surgical repair of SLAP lesions state that SLAP lesions may warrant surgical treatment in certain cases. Surgical intervention may be considered for patients failing conservative treatment. Guideline criteria have been met. There are clinical exam and imaging evidence consistent with impingement and a SLAP tear. There is documented functional difficulty impeding return to work. Evidence of 3 to 4 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Assistant Surgeon: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Centers for Medicare and Medicaid services, Physician Fee Schedule.

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 29822 and 29826, there is a "2" in the assistant surgeon column. For CPT Code 29807, there is a "1". Therefore, based on the stated guideline and the complexity of the procedure, this request is medically necessary.

Cold Therapy Unit: 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), Treatment Index, 12th Edition (web), 2014, Shoulder Chapter, 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 surgery. Postoperative use generally may be 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. The use of a cold therapy unit would be reasonable for 7 days post-operatively. However, this request is for an unknown length of use which is not consistent with guidelines. Therefore, this request is not medically necessary.

Post-Op physical therapy x 12 Left Shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

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 postsurgical physical medicine period. This initial request for post-op physical therapy is consistent with guidelines. Therefore, this request is medically necessary.

