

Case Number:	CM13-0066487		
Date Assigned:	01/03/2014	Date of Injury:	12/14/2011
Decision Date:	05/21/2014	UR Denial Date:	11/19/2013
Priority:	Standard	Application Received:	12/16/2013

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 Orthopaedic Surgery and is licensed to practice in California. 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 31-year-old male cook sustained an industrial injury on 12/14/11. He slipped in oil, fell on his left side, and heard a pop in his shoulder with immediate onset of pain. The 12/22/11 left shoulder MRI findings included prominent subchondral cyst within the superolateral aspect of the humeral head, downward sloping acromion, and supraspinatus tendinosis. The 5/23/12 cervical MRI was unremarkable. The 9/10/13 left shoulder MR arthrogram showed no evidence of a rotator cuff tear, and no definite labral tear. The 9/17/13 orthopedic progress report cited progressively worsening left shoulder pain, with functional difficulty in overhead activities, activities of daily living, and sleep. The patient had undergone an extensive and comprehensive Final Determination Letter for IMR Case Number CM13-0066487 3 course of conservative treatment with no long-term relief. Non-operative treatment included rest, ice, heat, activity modification, anti-inflammatories, pain medication, self-directed stretching and strengthening exercises, a series of corticosteroid injections, and physical therapy. Left shoulder exam findings documented flexion and abduction 155 degrees with pain, internal rotation to the SI joint with pain, positive Neer and Hawkins impingement signs, and tenderness over the subacromial bursal space and shoulder girdle musculature. The treatment plan recommended a left shoulder diagnostic and operative arthroscopy. Significant lifestyle limitation was reported and the patient remained unable to work. The 10/10/13 utilization review recommended denial of the left shoulder arthroscopy. The 10/28/13 progress report indicated that left shoulder pain continued, most notably anterior and in the posterior scapular area. Exam was essentially unchanged from 9/17/13 with additional findings of positive O'Brien's and bicipital groove tenderness to palpation. The treating physician again requested surgical authorization given the significant pain and functional limitation despite extensive conservative treatment. The 11/19/13 utilization review denied the request for left shoulder diagnostic/operative arthroscopic debridement with

acromioplasty, resection of the coracoacromial ligament, and bursa as indicated, and possible distal clavicle resection. Denial was based on age, no x-ray findings of AC joint arthritis, and no MRI/MRA findings of rotator cuff tear/impingement or labral tear. Surgery was not supported for tendonitis or in the absence of clear clinical and radiographic evidence of a surgical lesion.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT SHOULDER DIAGNOSTIC/OPERATIVE ARTHROSCOPIC DEBRIDEMENT WITH ACROMIOPLASTY RESECTION OF CORACOACROMIAL LIGAMENT AND BURSA AS INDICATED, POSSIBLE DISTAL CLAVICLE RESECTION: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Diagnostic Arthroscopy, Surgery for Impingement Syndrome.

Decision rationale: Under consideration is a request for left shoulder diagnostic/operative arthroscopic debridement with acromioplasty, resection of the coracoacromial ligament, and bursa as indicated, and possible distal clavicle resection. The California MTUS guidelines do not provide recommendations for shoulder surgery in chronic cases. The Official Disability Guidelines state that diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Acromioplasty is recommended for patients with painful active arc of motion 90-130 degrees, pain at night, weak/absent abduction, rotator cuff or anterior acromial tenderness, positive impingement signs, positive diagnostic injection test, and positive MRI evidence of impingement, with failure of 3 to 6 months of conservative treatment. Guideline criteria have been met. This 31-year-old patient has significant pain and functional limitation precluding return to work. Records document pain at night, positive impingement signs, painful range of motion, anterior shoulder tenderness, short term relief with injection, and generalized 4/5 left upper extremity weakness. There is detailed Final Determination Letter for IMR Case Number CM13-0066487 4 documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment has been tried for more than 6 months and failed. Therefore, this request for left shoulder diagnostic/operative arthroscopic debridement with acromioplasty, resection of the coracoacromial ligament, and bursa as indicated, and possible distal clavicle resection is medically necessary.

POST-OP PHYSICAL THERAPY TIMES 12 SEESIONS: 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: Under consideration is a request for post-op physical therapy, 12 sessions. The California Post-Surgical Treatment Guidelines for acromioplasty recommend 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 left shoulder diagnostic/operative arthroscopic debridement with acromioplasty, resection of the coracoacromial ligament, and bursa as indicated, and possible distal clavicle resection is medically necessary. Guidelines criteria have been met. Therefore, this request for post-op physical therapy for 12 sessions is medically necessary.

PREOPERATIVE MEDICAL CLEARANCE: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute For Clinical Systems Improvement (ICSI). Preoperative Evaluation.

Decision rationale: The request under consideration is for pre-operative medical clearance. The California MTUS is silent regarding this request. Evidence based medical guidelines support appropriate pre-operative evaluation for patients undergoing anesthesia for orthopedic procedures. Records indicate that this 31-year-old patient has a negative past medical history for any medical conditions, and does not smoke. Family history is non-contributory. Review of systems has been documented within normal limits. There is no evidence to support the medical necessity of a medical clearance beyond the standard pre-operative visit. Therefore, this request for pre-operative medical clearance is not medically necessary.

DVT PROPHYLAXIS AN ANTIBIOTICS (PERI-OPERATIVE): Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg; Deep Vein Thrombosis (DVT) and Clinical Practice Guidelines for Antimicrobial Prophylaxis In Surgery. AM J Health Syst Pharm. 2013 FEB.

Decision rationale: The request under consideration is for DVT prophylaxis and antibiotics (peri-operative) California MTUS guidelines are silent with regard to DVT prophylaxis and the use of peri-operative antibiotics. The Official Disability Guidelines recommend monitoring the risk of peri-operative thromboembolic complications in both the acute and subacute postoperative periods for possible treatment, and identifying subjects who are at a high risk of developing venous thrombosis despite the rare occurrence of developing a pulmonary embolism following shoulder surgery. Clinical practice guidelines indicate that antimicrobial prophylaxis is reasonably recommended for patients undergoing elective orthopedic procedures. Guideline

criteria have been met. Compression stockings would be typically sufficient prophylaxis to address post-operative concerns of DVT development. Therefore, this request for DVT prophylaxis and antibiotics (peri-operative) is medically necessary.

ASSISTANT SURGEON: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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

Decision rationale: Under consideration is a request for assistant surgeon. The California MTUS and Official Disability Guidelines do not provide recommendations for assistant surgeons. The Centers for Medicare & Medicaid Services (CMS) provide guidelines for surgical procedures which are eligible for an 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 CPT codes 29826, a number 2 was listed. Therefore, the request for an assistant surgeon is medically necessary.