

Case Number:	CM14-0009474		
Date Assigned:	02/14/2014	Date of Injury:	06/08/2011
Decision Date:	06/24/2014	UR Denial Date:	01/14/2014
Priority:	Standard	Application Received:	01/24/2014

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 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 58-year-old male sales associate sustained an industrial injury 6/8/11, when he fell attempting to move a case of candy. The patient was diagnosed with a non-displaced fracture of the right proximal humerus and a rotator cuff tear. Initial conservative treatment was provided, including physical therapy, but the patient failed to improve. Surgery was requested on 7/14/11 for a right shoulder arthroscopy with subacromial decompression and rotator cuff repair, and approved. The patient did not undergo surgery as he was unable to obtain medical clearance due to non-industrial problems. Conservative treatment has included medication management and activity restriction. Co-morbidities include congestive heart failure, diabetes, and hypertension. The 12/2/14 initial orthopedic consult report cited moderate right shoulder pain that is aggravated with lifting, carrying, and range of motion. Previous physical therapy reportedly did not help. Right shoulder exam noted normal range of motion, pain throughout range of motion, positive impingement sign, positive shrug sign, and positive arc of motion. Supraspinatus isolation strength was 4/5 and external rotation strength was 4+/5. The acromioclavicular joint was normal in prominence and non-tender, with no subclavicular joint enlargement. X-rays showed no fracture, no dislocation, well-preserved joint spaces, and normal alignment. An MRI was requested. The 12/18/13 right shoulder MRI conclusion documented small full-thickness tear of the supraspinatus tendon near its insertion on the humeral head, moderate osteoarthritis of the acromioclavicular joint, and moderate bursitis. The 1/6/14 progress report reported MRI findings of a full thickness rotator cuff tear and recommended right shoulder arthroscopy with rotator cuff repair, subacromial decompression, and excision distal clavicle. The 1/14/14 utilization review denied the surgical request noting an absence of guideline required subjective and objective findings, and no recent conservative treatment, including cortisone injections. The 2/5/14 appeal stated that the patient had undergone formal physical therapy and had been treated

for over 6 months. Clinical findings documented a painful arc of motion, night pain that awakens him, weakness and tenderness over the rotator cuff, acromioclavicular joint tenderness, and positive impingement sign. Imaging findings confirm a full thickness rotator cuff. The orthopedist stated that the patient had failed conservative management and that corticosteroid injections are contraindicated for a patient with a full thickness rotator cuff tear. He again requested authorization of the requested surgery.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT SHOULDER ARTHROSCOPY WITH ROTATOR CUFF REPAIR: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM, CHAPTER 9 - SHOULDER COMPLAINTS, 210-211

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Surgery For Rotator Cuff Repair.

Decision rationale: The California MTUS guidelines do not address rotator cuff repair for chronic injuries. The Official Disability Guidelines for rotator cuff repair with a diagnosis of full thickness tear typically require clinical findings of shoulder pain and inability to elevate the arm, weakness with abduction testing, atrophy of shoulder musculature, usually full passive range of motion, and positive imaging evidence of rotator cuff deficit. Guideline criteria have been met. This patient presents with subjective and objective clinical exam findings consistent with imaging of a full-thickness rotator cuff tear. Medications and activity restrictions have been tried and failed. Therefore, this request for right shoulder arthroscopy with rotator cuff repair is medically necessary.

SUBACROMIAL DECOMPRESSION: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM, CHAPTER 9 - SHOULDER COMPLAINTS, 210-211

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder Chapter, Surgery For Impingement Syndrome.

Decision rationale: The California MTUS guidelines do not provide recommendations for shoulder surgery in chronic cases. The Official Disability Guidelines for shoulder impingement surgery generally require 3 to 6 months of conservative treatment plus weak or absent abduction, positive impingement sign with a positive diagnostic injection test, and positive imaging evidence of impingement. This patient presents with positive clinical exam and imaging findings of impingement with rotator cuff weakness. Reasonable conservative treatment has been tried

and failed. Guideline criteria have been met. Therefore, this request for subacromial decompression is medically necessary.

WITH ASSISTANT (PHYSICIAN'S ASSISTANT): 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 & Medicaid Services, Physician Fee Schedule.

Decision rationale: California MTUS guidelines do not address the appropriateness of surgical assistants. 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 the requested surgical procedures, CPT Codes 29827, 29826 and 29882, there is a "1" or a "2" in the assistant surgeon column. Therefore, based on the stated guideline and the complexity of the procedure, this request for a surgical assistant (physician's assistant) is medically necessary.

EXCISION DISTAL CLAVICLE: 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 ODG, Shoulder Chapter, Partial Claviculectomy.

Decision rationale: The California MTUS guidelines do not address shoulder surgeries for chronic injuries. The Official Disability Guidelines for partial claviculectomy generally require 6 weeks of directed conservative treatment, subjective and objective clinical findings of acromioclavicular (AC) joint pain, and imaging findings of AC joint post-traumatic changes, severe degenerative joint disease, or AC joint separation. Guideline criteria have been met. There are clinical exam findings of acromioclavicular joint tenderness and imaging findings of moderate acromioclavicular joint osteoarthritis. Reasonable conservative treatment has been tried and failed. Therefore, this request for distal clavicle excision is medically necessary.