

Case Number:	CM14-0154620		
Date Assigned:	09/24/2014	Date of Injury:	07/08/2011
Decision Date:	10/27/2014	UR Denial Date:	08/19/2014
Priority:	Standard	Application Received:	09/22/2014

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 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:

The injured worker is a 63 year-old male lead warehouse person who sustained an industrial injury on 7/8/11. The mechanism of injury was not documented. Past medical history was positive for asthma, diabetes, high cholesterol, and hypertension. Past surgical history was positive for a left rotator cuff repair on 7/3/08. The 12/3/13 left shoulder magnetic resonance imaging (MRI) and magnetic resonance (MR) arthrogram studies documented mild acromioclavicular osteoarthritis, mild glenohumeral osteoarthritis with labral fissuring, infraspinatus tendinitis, and positive subacromial/subdeltoid bursitis. There was a focal full thickness supraspinatus tear at its insertion without evidence of tendinous retraction. The 5/27/14 right shoulder x-ray report impression documented mild osteopenia and minimal degenerative joint disease of the glenohumeral joint. The 4/30/14 treating physician report cited complaints of on-going bilateral shoulder pain and weakness, left far worse than right. The pain increased with above shoulder level activities or lifting more than 5 pounds. Left shoulder exam documented range of motion as flexion 90, abduction 90, internal rotation 70, and external rotation 80 degrees. There was tenderness to palpation over the biceps tendon, acromioclavicular joint, and anterior, posterior and lateral deltoid. Impingement, Neer's, Hawkin's and empty can tests were positive. Bilateral upper extremity strength was 5/5 with intact sensation. A corticosteroid injection to the right shoulder was deferred due to his diabetes. A corticosteroid injection was provided to the left shoulder. The 7/9/14 treating physician report cited continued left shoulder pain, weakness and limited range of motion. Difficulty was noted in sleeping on the left side, reaching overhead, combing his hair, and putting on and off his shirt. Left shoulder exam documented tenderness to palpation over the acromioclavicular joint and anterior/lateral borders of the acromion. Impingement, Neer's, Hawkin's and empty can tests were positive. There was mild loss in shoulder flexion, abduction, internal rotation and external rotation. The diagnosis

was shoulder impingement syndrome with tendinitis/bursitis, acromioclavicular and glenohumeral arthritis, and status post prior rotator cuff repair. A prior cortisone injection alleviated pain for a number of weeks, but symptoms had again returned. The treating physician cited on-going failure of conservative treatment for the left shoulder including physical therapy, anti-inflammatory medication, and corticosteroid injection. There were clinical and magnetic resonance imaging (MRI) findings consistent with a full thickness rotator cuff tear. Authorization was requested for left shoulder arthroscopy, subacromial decompression, rotator cuff repair, and possible Mumford procedure. The 8/19/14 utilization review denied the left shoulder surgery and associated requests as it was unlikely that a rotator cuff repair in the presence of glenohumeral joint arthritis would offer any additional benefit given his age.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder arthroscopy,: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Official Disability Guidelines (ODG).

Decision rationale: The ACOEM 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 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. Guideline criteria have been met. Subjective and clinical exam findings are consistent with imaging evidence of a full thickness rotator cuff tear. Evidence of 4 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Functional difficulty in activities of daily living is documented. Glenohumeral and acromioclavicular joint osteoarthritis is documented as minimal to mild. Current imaging findings documented minimal to mild degenerative joint disease of the acromioclavicular and glenohumeral joints. Therefore, this request is medically necessary.

subacromial decompression: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

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).

Decision rationale: The ACOEM 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 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. Guideline criteria have been met. Subjective and clinical exam findings are consistent with imaging evidence of a full thickness rotator cuff tear. Evidence of 4 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Functional difficulty in activities of daily living is documented. Glenohumeral and acromioclavicular joint osteoarthritis is documented as minimal to mild. Current imaging findings documented minimal to mild degenerative joint disease of the acromioclavicular and glenohumeral joints. Therefore, this request is medically necessary.

Rotator cuff repair and possible mumford procedure: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

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).

Decision rationale: The ACOEM 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 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. Guideline criteria have been met. Subjective and clinical exam findings are consistent with imaging evidence of a full thickness rotator cuff tear. Evidence of 4 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Functional difficulty in activities of daily living is documented. Glenohumeral and acromioclavicular joint osteoarthritis is documented as minimal to mild. Current imaging findings documented minimal to mild degenerative joint disease of the acromioclavicular and

glenohumeral joints. Guideline criteria have been met. Therefore, this request is medically necessary.

Assistant surgeon: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

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 (<http://www.cms.gov/apps/physician-fee-schedule>)

Decision rationale: 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 29827, 29836, and 29824, there is a "2" in the assistant surgeon column for each procedure. Therefore, based on the stated guideline and the complexity of the procedure, this request is medically necessary.

Medical Clearance: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

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): pages 522-38

Decision rationale: Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all injured workers undergoing diagnostic or therapeutic procedures. Guideline criteria have been met. This injured worker has a past medical history positive for diabetes, asthma and hypertension. Given these clinical indications and the risks of anesthesia, this request is medically necessary.

Postoperative Physical Therapy 3x4 left shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

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

Decision rationale: The MTUS Postsurgical 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-operative physical therapy is consistent with guidelines. Therefore, this request is medically necessary.