

Case Number:	CM14-0169627		
Date Assigned:	10/17/2014	Date of Injury:	10/31/2011
Decision Date:	11/20/2014	UR Denial Date:	09/13/2014
Priority:	Standard	Application Received:	10/14/2014

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 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 female janitor sustained an industrial injury on 10/31/11. Injury to the right shoulder occurred while shoveling trash into a dumpster. Past surgical history was positive for right carpal and cubital tunnel release on 11/13/13. Records documented medication allergies to Voltaren and acetaminophen. The 1/31/12 right shoulder MRI impression documented evidence of impingement with downsloping acromion process impinging on the supraspinatus tendon in the rotator cuff. There was fluid in the subacromial/subdeltoid bursa compatible with bursitis. Records documented 8 visits of physical therapy for the right shoulder from 4/4/14 to 5/6/14. There was improvement in range of motion with persistent abduction weakness, painful resisted supraspinatus strength, and positive impingement signs. Continued functional difficulty was noted in activities of daily living and exercise. The 8/20/14 initial orthopedic report cited constant grade 6/10 right shoulder pain radiating into her neck. Pain increased to grade 9/10 with lifting, carrying, pulling, pushing, and reaching overhead. Pain decreased with medications. A prior right shoulder corticosteroid injection was reported with temporary benefit. MRI findings showed evidence of impingement on the supraspinatus tendon and subacromial/subdeltoid bursitis. Physical exam documented tenderness to palpation over the greater tuberosity in the area of the supraspinatus tendon, long head of the biceps tendon, and the trapezius, levator, and rhomboid muscle groups with spasms. The acromioclavicular joint was non-tender. Right shoulder range of motion was documented as extension 60, flexion 160, internal rotation 60, external rotation 60, abduction 150, and adduction 50 degrees. There was 4/5 abduction weakness. Neer's, Hawkin's, and impingement tests were positive. Cross arm and apprehension tests were negative. The diagnosis was impingement syndrome and tendinitis right shoulder. Authorization was requested for right shoulder diagnostic arthroscopy with subacromial decompression and distal clavicle excision and associated pre-op/post-op services and items. The

9/13/14 utilization review denied the right shoulder arthroscopy and associated requests were denied based on an absence of documented conservative treatment and no clinical evidence of acromioclavicular joint pain, tenderness, or imaging changes.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Right shoulder diagnostic arthroscopy w/subacromial decompressions & excision distal clavicle between 9/5/2014 and 11/08/2014: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211. Decision based on Non-MTUS Citation Official Disability Guidelines: Indications for Surgery--Partial Claviclectomy; Acromioplasty

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, Partial Claviclectomy

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 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, positive impingement sign with a positive diagnostic injection test, and imaging findings showing positive evidence of impingement. Guideline criteria for Partial Claviclectomy generally include 6 weeks of directed conservative treatment, subjective and objective clinical findings of acromioclavicular (AC) joint pain, positive diagnostic injection, and imaging findings of AC joint pathology. Guideline criteria have been met. This patient presents with clinical exam and imaging findings consistent with impingement. Positive temporary injection response is documented. Functional limitations are noted and preclude return to work. Evidence of 3 to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Associated surgical service: 1 Assistant surgeon: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Centers for Medicare & Medicaid Services, Physician Fee Schedule Search, and CPT Code 27447

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 code 29826, 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.

Associated surgical service: 1 Post-Operative medication: Percocet 5/325mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Post-Operative: Opioids, Criteria for Use, Percocet Page(s): 76-80, 92, 97.

Decision rationale: The California MTUS guidelines support the short term use of opioid medications for shoulder complaints. Guidelines recommend Percocet (Oxycodone/Acetaminophen) for moderate to severe pain on an as needed basis for pain. Although, a short course of post-operative opioid pain medication is consistent with guidelines, this patient is reported as allergic to Acetaminophen. Given this reported medication allergy, the use of Percocet is contraindicated. Therefore, this request is not medically necessary.

Associated surgical service: 2 weeks rental post-operative cold compression unit: Upheld

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 Official Disability Guidelines (ODG) Shoulder, Cold Compression Therapy

Decision rationale: The California MTUS is silent regarding cold compression devices. The Official Disability Guidelines state that cold compression therapy is not recommended in the shoulder. Guidelines state that there has been a randomized controlled trial since 2008 to evaluate and compare clinical post-operative outcomes for patients using an active cooling and compression device, and those using ice bags and elastic wrap after acromioplasty or arthroscopic rotator cuff repair, but the results are not available. There is no compelling reason submitted to support the medical necessity of a cold compression unit over simple cold packs. Therefore, this request is not medically necessary.