

Case Number:	CM14-0199304		
Date Assigned:	12/09/2014	Date of Injury:	02/11/2008
Decision Date:	01/28/2015	UR Denial Date:	10/27/2014
Priority:	Standard	Application Received:	11/26/2014

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 is a 57 year old female with a 2/11/08 injury date. A 5/5/14 left shoulder MRI revealed rotator cuff tendinosis and no evidence of rotator cuff tear. In a 9/4/14 orthopedic note, the patient complained of left shoulder pain that causes difficulty sleeping at night. Objective findings included a left shoulder painful arc of motion, positive impingement signs, forward flexion to 120 degrees, abduction to 120 degrees, and pain when placing the arm behind the back. The patient has failed a significant amount of conservative treatment over 6 years. The provider's plan was to perform a subacromial decompression followed by rotator cuff repair only if a full-thickness tear is present. In a 3/1/14 ortho CME, the provider recommended left shoulder arthroscopy in the near future. Diagnostic impression: left shoulder impingement syndrome. Treatment to date: physical therapy, medications, injections. A UR decision on 10/27/14 denied the request for left shoulder arthroscopy with decompression and possible rotator cuff repair because there was no indication that the patient had 3-6 months of conservative treatment, there was no documented night pain, and no MRI imaging was recorded. The request for assistant surgeon was denied because the associated procedure was not certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopy Decompression and Possible Repair Rotator Cuff: 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): Shoulder Chapter--Rotator cuff repair, Surgery for impingement syndrome

Decision rationale: The California MTUS states that surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. In addition, MTUS states that surgical intervention should include clear clinical and imaging evidence of a lesion that has been shown to benefit from surgical repair. Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery. The California MTUS states that rotator cuff repair is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation; conservative treatment of full thickness rotator cuff tears has results similar to surgical treatment, but without the surgical risks, and further indicate that surgical outcomes are not as favorable in older patients with degenerative changes about the rotator cuff. In addition, Official Disability Guidelines criteria for repair of full-thickness rotator cuff tears include a full-thickness tear evidenced on MRI report. In this case, the patient has documented shoulder pain at night that inhibits sleep and continues to have significant left shoulder symptoms despite appropriate conservative treatment. Conservative treatment in the past has included physical therapy, medications, and subacromial cortisone injections that have only provided short-term relief. Although the MRI does not clearly show a rotator cuff tear, there are findings of tendinosis, and a small full-thickness tear is often difficult to exclude. The requested surgery was also recommended in a recent ortho CME note. At this time, the patient is a good candidate for arthroscopic subacromial decompression. If a small full-thickness cuff tear is found during surgery, repair of that tear would be indicated. Therefore, the request for left shoulder arthroscopy decompression and possible repair rotator cuff 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 Other Medical Treatment Guideline or Medical Evidence: American Association of Orthopaedic Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics

Decision rationale: The California MTUS does not address this issue. American Association of Orthopaedic Surgeons Position Statement Reimbursement of the First Assistant at Surgery in Orthopaedics states on the role of the First Assistant: According to the American College of Surgeons: "The first assistant to the surgeon during a surgical operation should be a trained individual capable of participating and actively assisting the surgeon to establish a good working team. The first assistant provides aid in exposure, hemostasis, and other technical functions, which will help the surgeon carry out a safe operation and optimal results for the patient. The role will vary considerably with the surgical operation, specialty area, and type of hospital. "The

first assistant's role has traditionally been filled by a variety of individuals from diverse backgrounds. Practice privileges of those acting as first assistant should be based upon verified credentials reviewed and approved by the hospital credentialing committee (consistent with state laws)." In general, the need for an assistant surgeon is under the discretion of the operating surgeon. In this case, an assistant surgeon is necessary given the possibility of a rotator cuff repair. Therefore, the request for assistant surgeon is medically necessary.