

Case Number:	CM15-0000663		
Date Assigned:	02/19/2015	Date of Injury:	03/18/2002
Decision Date:	04/01/2015	UR Denial Date:	12/09/2014
Priority:	Standard	Application Received:	01/02/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 was a 73-year-old man who sustained an industrial injury on 3/18/02, relative to cumulative trauma. He underwent left shoulder rotator cuff repair on 11/3/10. Records indicated that a right shoulder MRI on 2/29/12 demonstrated a massive full thickness rotator cuff tear with retraction of the musculotendinous unit of supraspinatus and infraspinatus tendons and large bursal tear of the subscapularis tendon. The 10/29/14 treating physician report cited frequent moderate right shoulder pain, increased with work above shoulder level. Physical exam documented decreased right shoulder range of motion and tenderness. The treatment plan recommended continued Terocin patches for targeted pain relief and follow-up with orthopedist for right shoulder. The 11/14/14 orthopedic report documented follow-up for his right shoulder. Physical exam documented positive arc from 90 to 110 degrees in forward flexion, forward elevation and abduction. There was no instability to ligamentous stress testing. Hawkin's and Neer impingement signs were positive. Authorization for right shoulder surgery was requested. A 12/2/14 request for right shoulder arthroscopy, possible right arthroscopic versus open decompression with acromioplasty, rotator cuff debridement versus repair, resection of coracoacromial ligament and/or bursa as indicated, and Mumford procedure, was noted as an extension of the authorization on 4/28/14. On 12/9/14, utilization review evaluated a prescription for outpatient right shoulder arthroscopy, possible right arthroscopic versus open decompression with acromioplasty, rotator cuff debridement versus repair, resection of coracoacromial ligament and/or bursa as indicated, and Mumford procedure, with assistant surgeon, that was submitted on 12/11/14. The UR physician noted there was no documentation of recent imaging or treatment.

The MTUS, ACOEM Guidelines, (or ODG) was cited. The request was denied and subsequently appealed to Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient Right Shoulder Arthroscopy: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers Comp, 19th Edition, 2014 updates: Shoulder Procedure.

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

Decision rationale: The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. Guideline criteria have been met. This patient presents with chronic function-limiting right shoulder pain. Clinical exam findings were consistent with imaging evidence of a massive rotator cuff tear and plausible impingement. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Possible Arthroscopic vs. Open Decompression with Acromioplasty: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers Comp, 19th Edition, 2014 updates: Shoulder Procedure.

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.

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. Surgery for impingement syndrome is usually arthroscopic decompression. The Official Disability Guidelines provide more specific indications for acromioplasty and impingement syndrome 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. Conventional x-rays, AP, and true lateral or auxiliary view, AND MRI, ultrasound, or arthrogram showing positive evidence of impingement are required. Guideline criteria have been met. This patient presents with chronic function-limiting right shoulder pain. Clinical

exam findings were consistent with imaging evidence of a massive rotator cuff tear and plausible impingement. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Rotator Cuff Debridement vs. Repair: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers Comp, 19th Edition, 2014 updates: Shoulder Procedure.

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 rotator cuff repair.

Decision rationale: The California MTUS guidelines provide general recommendations for rotator cuff repair with surgery reserved for cases failing conservative treatment for three months. Guidelines state that surgical outcomes in rotator cuff tear are much better in younger patients. 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, and positive imaging evidence of rotator cuff deficit. Guideline criteria have been met. This patient presents with chronic function-limiting right shoulder pain. Clinical exam findings were consistent with imaging evidence of a massive rotator cuff tear and plausible impingement. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Resection of Coracoacromial Ligament and/or Bursa as indicated: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers Comp, 19th Edition, 2014 updates: Shoulder Procedure.

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.

Decision rationale: The California MTUS guidelines do not provide specific recommendations for Mumford procedure. The Official Disability Guidelines provide specific criteria for partial claviclectomy that generally require 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 post-traumatic changes, severe degenerative joint disease, or AC joint separation. Guideline criteria have been met. This patient presents with chronic function-limiting right shoulder pain. Clinical exam findings were consistent with imaging evidence of a massive rotator cuff tear and plausible impingement. Detailed evidence of a recent,

reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Mumford Procedure: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers Comp, 19th Edition, 2014 updates: Shoulder Procedure.

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: Partial claviclectomy.

Decision rationale: The California MTUS guidelines do not provide specific recommendations for Mumford procedure. The Official Disability Guidelines provide specific criteria for partial claviclectomy that generally require 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 post-traumatic changes, severe degenerative joint disease, or AC joint separation. Guideline criteria have been met. This patient presents with chronic function-limiting right shoulder pain. Clinical exam findings were consistent with imaging evidence of a massaged rotator cuff tear and plausible impingement. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. Therefore, this request is medically necessary.

Assistant Surgeon: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Milliman Care Guidelines 18th Edition: Assistant Surgeon; and on the Assistant Surgeon 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, Assistant Surgeons <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>.

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, 28824, and 29827, there is a "2" in the assistant surgeon column for each code. Therefore, based on the stated guideline and the complexity of the procedure, this request is medically necessary.