

Case Number:	CM15-0051355		
Date Assigned:	06/03/2015	Date of Injury:	05/06/2009
Decision Date:	07/07/2015	UR Denial Date:	02/24/2015
Priority:	Standard	Application Received:	03/18/2015

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 is a 56-year-old female who sustained an industrial injury on 5/06/09. Injury occurred when she slipped on a wet floor and fell as she opened a door. Past medical history included hyperlipidemia, hypertension, positive TB test, coronary artery disease, gastroesophageal reflux disease, ischemic colitis, and asthma. She underwent left shoulder arthroscopy with subacromial decompression/acromioplasty, extensive synovectomy, bursectomy, full thickness rotator cuff repair, and Mumford procedure on 8/13/10, and right shoulder arthroscopic surgery on 3/4/11. The 1/28/15 left shoulder MR arthrogram impression documented near complete tear of the supraspinatus tendon with a few residual posterior fibers attached at the site of the greater tuberosity suture anchors. There was interval progression in infraspinatus tendinosis with a new high-grade partial tear of the anterior insertional fibers. There was partial and interstitial tear of the mid fibers of the subscapularis tendon. There was mild acromioclavicular (AC) joint degenerative joint disease. The 2/3/15 treating physician report cited progressively worsening left shoulder pain. Pain caused difficulty with left arm use and sleeping. She had completed physical therapy and continued self-directed exercises without good result. Physical exam documented bilateral shoulder range of motion (right/left) as follows: flexion 100/90, abduction 90/90, external rotation 90/90, internal rotation 80/80, extension 40/30, and adduction 10/10 degrees. There was pain at extremes of motion. There was moderate tenderness to deep palpation of both shoulders and negative impingement sign. There was focal AC joint and greater tuberosity tenderness. The diagnosis was recurrent left shoulder rotator cuff tear and symptomatic left AC degenerative arthritis. The injured worker had failed extensive treatment since surgery with physical therapy, home exercise, oral medications, and multiple corticosteroid injection with only temporary symptomatic relief. Authorization was requested for

left shoulder arthroscopy, debridement, rotator cuff repair, and distal clavicle excision as outpatient, with pre-operative medical clearance, pre-operative EKG, surgical assistant, and post-operative physical therapy 12 sessions, now under review. The 2/24/15 utilization review non-certified the left shoulder arthroscopy, debridement, rotator cuff repair, and distal clavicle excision and associated surgical requests as the injury was over 5 years old and there was a chronic tear with retraction, poor range of motion, and prior failed surgery. The 3/17/15 treating physician report cited unchanged left shoulder pain, weakness and limited range of motion. She had been unable to wean off narcotic medications due to pain. Physical exam documented left shoulder range of motion as forward flexion 130, abduction 130, external rotation 90, internal rotation 60, extension 40, and adduction 20 degrees. There was tenderness to palpation over the anterior shoulder and greater tuberosity. There was 3-4/10 left shoulder flexion and abduction weakness. Arthroscopic treatment of the left shoulder was opined as reasonable given pain, weakness and limited motion. The right shoulder remained symptomatic but was improved after surgery and conservative treatment was appropriate. The left shoulder symptoms were significantly restricting use and normal daily activities. There was reasonable likelihood of clinical and functional improvement with requested surgical treatment. Appeal was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Arthroscopy, Debridement, Rotator Cuff Repair, Distal Clavicle Excision as Outpatient: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

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; Surgery for impingement syndrome, Partial claviclectomy.

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. For partial thickness rotator cuff tears and small full thickness tears presenting as impingement, surgery is reserved for cases failing conservative treatment for 3 months. The Official Disability Guidelines for rotator cuff repair of partial thickness tears generally require 3 to 6 months of conservative treatment, plus painful arc of motion 90-130 degrees and pain at night, plus weak or absent abduction, rotator cuff or anterior acromial tenderness, and positive impingement sign with a positive diagnostic injection test. Criteria include imaging evidence of a rotator cuff deficit. Guideline criteria for partial claviclectomy 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. This injured worker presents with persistent left shoulder pain and significant functional limitations in arm use and activities of daily living. Clinical exam findings are consistent with imaging evidence of near complete re-tear of the rotator cuff and AC

degenerative joint disease. A positive diagnostic injection test was documented. 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.

Pre-Operative Medical Clearance - Labs: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation
<http://www.medscape.com/medline/abstract/8441296>,
<http://emedicine.medscape.com/article/285191-overview#a1>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation. Bloomington (MN).

Decision rationale: The California MTUS guidelines do not provide recommendations for pre-operative medical clearance. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. Although, pre-operative medical clearance and basic lab testing would be supported for this injured worker based on age and medical co-morbidities, the medical necessity of a non-specific lab request cannot be established. Therefore, this request is not medically necessary.

Pre-Operative EKG: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation
<http://www.medscape.com/medline/abstract/8441296>,
<http://emedicine.medscape.com/article/285191-overview#a1>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Practice advisory for preanesthesia evaluation.

Decision rationale: The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines indicate that most laboratory tests are not necessary for routine procedures unless a specific indication is present. Indications for such testing should be documented and based on medical records, patient interview, physical examination, and type and invasiveness of the planned procedure. Guidelines state that an EKG may be indicated for patients with known cardiovascular risk factors or for patients with risk factors identified in the course of a pre-anesthesia evaluation. Guideline criteria have been met based on patient age, cardiac history, and the risks of undergoing anesthesia. Therefore, this request is medically necessary.

Associated Surgical Service: Surgical 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 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 codes 29827 and 29824 are referenced. Therefore, based on the stated guideline and the complexity of the procedure, this request is medically necessary.

Post-Operative Physical Therapy 12 Sessions: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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

Decision rationale: The California MTUS Post-Surgical 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 is the initial request for post-operative physical therapy and is consistent with guidelines. Therefore, this request is medically necessary.