

Case Number:	CM14-0210140		
Date Assigned:	12/23/2014	Date of Injury:	02/01/2014
Decision Date:	02/19/2015	UR Denial Date:	11/19/2014
Priority:	Standard	Application Received:	12/15/2014

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. 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: California

Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

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 injured worker is a 48-year-old male with a date of injury of 02/01/2014. The mechanism of injury was while working for the [REDACTED], noted pain and discomfort after lifting weights. His past treatment has included 10 sessions of physical therapy, 2 cortisone shots in the subacromial space. Diagnostic studies included an MRI that was completed on 04/18/2014, indicating a moderate to severe low lying type II acromion with mild anterior downsloping present, minimal AC joint osteoarthritis and capsular thickening without evidence of acute edema. His surgical history included to treat his fistula; however, he denies any surgical history for his right shoulder. On 11/06/2014, the injured worker complained of achiness, stiffness and pain, especially with overhead activities, as well as with internal and external rotation. He rated his pain as an 8 to 10 and describes it as sharp and burning, and states any time he reaches about his shoulder or to reach behind, he experiences excruciating pain. Physical examination revealed full range of motion of the cervical spine. Range of motion of the right shoulder forward flexion to 155 degrees, abduction to 155 degrees, external rotation to 90 degrees and internal rotation T8. There is no atrophy of the upper arm or forearm and no parascapular muscular wasting. Motor strength was normal bilaterally. There is no tenderness at the acromioclavicular joint. No evidence of superior migration of the distal clavicle with inferior traction on the arm. There is no tenderness at the sternoclavicular joint and no subluxation or instability of the joint. There is no tenderness at the parascapular bursa and over at the subacromial bursa. There is no tenderness at the greater tuberosity. There is positive Neer impingement and positive Hawkins sign. The injured worker was not taking any current

medications. The treatment plan is for right shoulder diagnostic arthroscopic surgery. The request is for right shoulder diagnostic/operative arthroscopic debridement with acromioplasty resection of the coracoacromial ligament and bursa as indicated, possible distal clavicle resection with examination and manipulation under anesthesia; the rationale is he has already completed conservative modalities of rest, ice, anti-inflammatories, analgesics, home stretching and strengthening exercise program, formal physical therapy and 2 subacromial cortisone injections without any real long term relief. Request for Authorization was included.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Shoulder diagnostic/operative Arthroscopic Debridement with Acromioplasty resection of Coracoacromial Ligament and Bursa as indicated possible Distal Clavicle resection with examination and manipulation under anesthesia: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for impingement syndrome

Decision rationale: The request for Right Shoulder diagnostic/operative Arthroscopic Debridement with Acromioplasty resection of Coracoacromial Ligament and Bursa as indicated possible Distal Clavicle resection with examination and manipulation under anesthesia is not medically necessary. The injured worker was seen for a preoperative consultation and complained of a sharp burning pain in the right shoulder whenever he reaches. According to the California MTUS/ACOEM Guidelines, surgical considerations depend on the diagnosis as a presenting shoulder complaint. According to the Official Disability Guidelines, the criteria for surgery of an acromioplasty is conservative care recommended of 3 to 6 months, plus subjective clinical findings of range of motion 90 to 130 degrees and pain at night, plus weak or absent abduction and tenderness over the rotator cuff and positive impingement sign, plus x-rays, MRIs, ultrasound, or arthrograms with positive evidence of impingement. The documentation indicated that the physical examination findings did not indicate any tenderness over the acromioclavicular joint or the bursa or the subacromial bursa, and there were no complaints by the injured worker of night time pain. The MRI did not substantiate evidence of impingement. As such, the request for Right Shoulder diagnostic/operative Arthroscopic surgery is not supported by the guidelines. Therefore, the request is not medically necessary.

Associated Surgical Services: Assistant Surgeon: 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) (ODG) Low Back, Surgical assistant,

Decision rationale: The injured worker was seen for a preoperative consultation and complained of a sharp burning pain in the right shoulder whenever he reaches. The California MTUS/ACOEM Guidelines do not address surgical assistants. The Official Disability Guidelines addresses surgical assistant as necessary for complicated surgeries. The Centers of Medicare and Medicaid Services (CMS) state that the list of surgical procedures which are eligible for an assistant at surgery are procedure codes with a 0 under the assistant surgery heading and imply that an assistant is not necessary, however, procedures codes with 1 or 2 implies that an assistant is usually necessary. For CPT code 29823, a number 1; therefore, an assistant surgeon is recommended. As the requested primary service of the surgery is not supported by the documentation, the request for the associated service of the surgical assistant would not be supported. As such, the request is not medically necessary.

Associated Surgical Services: 1 Medical clearance with labs (CBC, CMP,PT/PTT, HEP/HIV panel, U/A, EKG, Chest X-ray): 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) Low Back, Preoperative testing, general

Decision rationale: The request for medical clearance with labs is not medically necessary. The injured worker was seen for a preoperative consultation and complained of a sharp burning pain in the right shoulder whenever he reaches. The California MTUS/ACOEM does not address. The Official Disability Guidelines for preoperative lab testing indicate it is recommended for the decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical findings. Patients with signs or symptoms of cardiovascular disease should be evaluated with appropriate testing. EKGs are recommended for patients undergoing high risk surgery and intermediate risk surgery who have additional risk factors. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications. The documentation as submitted did not indicate the injured worker is at risk for any cardiovascular disease, peripheral arterial disease, or other high risk health problems. The surgery is a low risk surgery. Therefore, it would not be indicated or supported by the guidelines. As the requested primary service of the surgery is not supported by the documentation, the request for the associated service is also not supported. Therefore, as such, the request for medical clearance with labs is not medically necessary.

Associated Surgical Services: 12 Post-Operative Physical Therapy session, Right Shoulder (REDACTED): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The request for 12 postoperative physical therapy sessions is not medically necessary. The injured worker was seen for a preoperative consultation and complained of a sharp burning pain in the right shoulder whenever he reaches. The California MTUS Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. The guidelines recommend up to 24 visits of physical therapy. Additionally, the guidelines recommend that injured workers should be formally assessed after a 6 visit clinical trial to see if the patient is moving in a positive direction, no direction or a negative direction, prior to continuing with physical therapy. The request for 12 visits exceeds the guideline recommendations. As such, the 12 sessions are not supported.

Associated Surgical Services: 1 Shoulder Sling ([REDACTED]): 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 Postoperative abduction pillow sling

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.