

<b>Case Number:</b>	CM15-0046408		
<b>Date Assigned:</b>	03/18/2015	<b>Date of Injury:</b>	08/29/2012
<b>Decision Date:</b>	04/23/2015	<b>UR Denial Date:</b>	03/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/11/2015

### 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 52-year-old male who sustained a work related injury on 8/29/12. Injury occurred while moving a pallet of bleach weighing approximately 30-40 pounds. He underwent a left shoulder arthroscopy with rotator cuff repair, subacromial decompression, distal clavicle resection, and glenoid microfracture chondroplasty on 8/14/14. He reported persistent pain following surgery. The 1/27/15 treating physician report cited continued left shoulder pain and weakness which has not significantly improved with independent exercise. Previous physical therapy was reported effective in improving motion, strength, and function. Physical exam documented tenderness to palpation over the superior left acromial area, good shoulder flexion/extension, and grip strength 47/46/52 kg right and 41/146/50 kg left. X-rays were obtained and showed evidence of a distal clavicle excision but there was an apparent superior osseous re-growth or exostosis protruding above the superior cortical surface of the distal clavicle. Type I acromial morphology was evident on the lateral projection. The diagnosis was persistent pain and tenderness around the distal left clavicle osseous prominence and incomplete post-operative functional recovery. The treatment plan recommended an injection into the area of the bony prominence. The 2/17/15 treating physician report indicated that the patient had symptomatic relief with the previous injection. Physical exam documented tenderness over the left acromioclavicular joint area and anterior biceps tendon. He had full shoulder range of motion with pain in abduction on the left. Speed's and empty can tests were negative. Findings did not suggest shoulder derangement so additional imaging was not required. The treatment plan requested arthroscopic surgical excision, removal of symptomatic bony prominence and

diagnostic arthroscopy to evaluate persistent pain and limited functional recovery. The patient remains disabled from his usual work. The 3/9/15 utilization review certified requests for left distal clavicle excision, pre-operative medical clearance, lab work and EKG, and post-operative physical therapy 12 visits. The requests for left shoulder arthroscopy with debridement, possible left shoulder arthroscopic repair as needed, and surgical assistant were not certified. The rationale for non-certification cited no imaging evidence of a rotator cuff tear and the previous acromioplasty appeared adequate, and there was no documentation of a corticosteroid injection.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Left shoulder arthroscopy with debridement: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter.

**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 persistent function-limiting left shoulder pain following arthroscopic subacromial decompression and rotator cuff repair. Clinical exam findings are consistent with x-ray findings of an apparent superior osseous re-growth or exostosis protruding above the superior cortical surface of the distal clavicle. The 3/9/15 utilization review certified a request for left distal clavicle excision. Despite the lack of updated post-operative MR imaging, additional surgical intervention beyond the current certification is reasonable in light of current clinical findings and plausible intra-operative findings. Therefore, this request is medically necessary.

#### **Possible arthroscopic repair, as needed, left shoulder: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter.

**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 persistent function-limiting left shoulder pain following arthroscopic subacromial decompression and rotator cuff repair. Clinical exam findings are consistent with x-ray findings of an apparent superior osseous re-growth or exostosis protruding above the superior cortical surface of the distal clavicle. The 3/9/15 utilization review certified a request for left distal clavicle excision. Despite the lack of updated post-operative MR imaging, additional surgical intervention beyond the current certification is reasonable in light of current clinical findings and plausible intra-operative findings. Therefore, this request is medically necessary.

**Surgical Assistant:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

**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, 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 29824, 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.