

Case Number:	CM14-0180053		
Date Assigned:	11/04/2014	Date of Injury:	01/04/2011
Decision Date:	12/12/2014	UR Denial Date:	10/23/2014
Priority:	Standard	Application Received:	10/29/2014

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:

The 48 years old male claimant with an industrial injury dated 01/04/11. Prior treatments have included surgery, physical therapy, medication, and injections. MR arthrogram of the shoulder dated 09/26/14 reveals a complete tear of the supraspinatus and infraspinatus tendons with retraction of approximately 4.5cm and 3.6cm. There were also moderate degenerative changes to the acromioclavicular joint and tendinosis of the biceps tendon. Exam note 10/01/14 states the patient underwent a bilateral shoulder rotator cuff repair. The patient continued to complain about bilateral shoulder pain. The patient was noted upon physical exam of the right shoulder there was a well-healed incision. The patient demonstrated a 3/5 motor strength with forward flexion and 4/5 with external and internal rotation. Range of motion is noted as 90' flexion, 90' abduction, and 50' external/internal rotation. There was swelling present over the first dorsal compartment. The right hand strength is noted as 65/55/50. Treatment includes a repeat arthroscopy of the right shoulder, and a DeQuervain's release.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder reverse arthroplasty: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, Reverse shoulder arthroplasty

Decision rationale: CA MTUS/ACOEM is silent on the issue of reverse shoulder replacement. Per the ODG, Shoulder section, Reverse shoulder arthroplasty, recommendations include patients who have shoulder arthritis with irreparable rotator cuff tear. Indications include per the ODG: "Non-functioning irreparable rotator cuff and glenohumeral arthropathy; or- Failed hemiarthroplasty or failed total shoulder arthroplasty with irreparable rotator deficiency; or- Comminuted fractures (3 or 4 part) of the proximal humerus in an older population (65 years of age or older)-And meet all of the following criteria: - Limited functional demands; - Intractable pain that has not responded to conservative therapy (including NSAIDs, intra-articular steroid injections, and physical therapy for at least 6 months and failed); - Adequate deltoid function; - Adequate passive range of motion to obtain functional benefit from the prosthesis; - Residual bone permits firm fixation of the implant; - No evidence of shoulder infection; - No severe neurologic deficiency." In this case there is lack of demonstration of 6 months of physical therapy, intra-articular steroid injection from the exam note from 9/26/14. Therefore, the request is not medically necessary.

Associated surgical service: shoulder immobilizer: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated surgical service: cold unit: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated surgical service: physical therapy shoulder 3x2: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.