MAXIMUS Federal Services

Case Number:	CM14-0052084		
Date Assigned:	07/07/2014	Date of Injury:	04/13/2009
Decision Date:	08/29/2014	UR Denial Date:	04/04/2014
Priority:	Standard	Application Received:	04/21/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in N. 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 injured worker is a 50-year-old female who was reportedly injured on April 13, 2009. The mechanism of injury is not listed in these records reviewed. The most recent progress note dated March 11, 2014, indicates that there are ongoing complaints of right shoulder pain. The physical examination demonstrated decreased right shoulder motion secondary to pain and a positive Hawkins and Neer's test. Diagnostic imaging studies of the right shoulder showed a pinhole tear in the anterior rotator cuff, partial anterior labral tear, and subcortical regions as well as a subcortical systole humeral head. Previous treatment includes a right shoulder subacromial decompression, distal clavicle excision, and many open rotator cuff repair in 2009 as well as a labral repair and lysosome adhesions, debridement, and hardware removal in 2010. There was also a subsequent mobilization under anesthesia, labral debridement, rotator cuff debridement, and loose body removal as well as lysosome adhesions in 2011. There was also use of a transcutaneous electrical nerve stimulation unit and subacromial injections. A request was made for right shoulder surgery, postoperative physical therapy, and a cold therapy unit and was not certified in the pre-authorization process on April 4, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder surgery total shoulder arthroplasty versus HemiCAP.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 209. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder Chapter, Arthroplasty

(shoulder); http://www.aetna.com/cpb/medical/data/600_699/0661.html; http://www.bcidaho.com/providers/medical_policies/.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Arthroplasty, Updated July 29, 2014.

Decision rationale: According to the Official Disability Guidelines the criteria for a shoulder arthroplasty includes severe pain or functional disability that interferes with activities of daily living as well as positive radiographic findings of shoulder joint degeneration and severe joint space stenosis. According to the medical record it does not state that the injured employee has severe pain and concordant functional disability nor are there any findings of severe joint space stenosis on X-rays nerve conduction test of the right shoulder. For these reasons this request for a right shoulder surgery total shoulder arthroplasty versus HemiCAP is not medically necessary.

(1) Postoperative Physical Therapy 2 times per week for 16: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Cold therapy 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: Shoulder Chapter, Continuous-flow cryotherapy.

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

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