

<b>Case Number:</b>	CM14-0062434		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	09/08/2012
<b>Decision Date:</b>	09/17/2014	<b>UR Denial Date:</b>	04/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/05/2014

### 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 Texas. 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 63-year-old female who reported an injury on 09/08/2012 due to cumulative trauma while performing normal job duties. The injured worker reportedly sustained an injury to her right shoulder. The injured worker was initially treated conservatively with medications and physical therapy. However, she had uncontrolled symptoms. The injured worker was evaluated on 09/26/2013. It was noted that the injured worker had progressive pain complaints of the right shoulder and significant difficulties in function. It was noted that the injured worker had a difficult time participating in the examination secondary to pain. It was noted that the injured worker's biceps appeared to be intact and that the injured worker had significant crepitus and markedly decreased range of motion. The injured worker's diagnoses included severe osteoarthritis of the shoulder. It was documented that the injured worker required a total shoulder replacement, as an arthroscopic procedure would not provide any relief. The injured worker underwent an MRI of the right shoulder dated 02/15/2014. It was documented that the injured worker had advanced osteoarthritic changes of the right shoulder with a full thickness cartilage loss, with bone on bone contact, and multiple intra-articular loose bodies. It was noted that the injured worker had a partial tear of the long head of the biceps tendon and an infraspinatus tear. The injured worker was evaluated on 03/20/2014. It was documented that the injured worker had difficulty sleeping and participating in activities of daily living secondary to shoulder pain. The injured worker's medications included Norco, tramadol, Lisinopril, naproxen, pantoprazole, and atenolol. It was noted that the injured worker had severe bone on bone contact with significantly limited activities of daily living that would require surgical intervention. A reverse shoulder arthroplasty was recommended. A Request for Authorization was submitted to support the request.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Right reverse shoulder arthroplasty:** 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) Shoulder.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-212.

**Decision rationale:** The requested Right reverse shoulder arthroplasty is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommend shoulder surgery for injuries that significantly limit injured workers functional capabilities and is supported by pathology identified on an imaging study that has failed to respond to conservative treatment. The clinical documentation submitted for review does indicate that the injured worker has significantly limited functionality with appropriate pathology identified on an imaging study that has failed to respond to conservative treatment. However, Official Disability Guidelines recommend the specific surgery of reverse shoulder arthroscopy for nonfunctioning irreparable rotator cuff and glen humeral arthropathy, or failed hemiarthroplasty, or failed total shoulder arthroplasty with irreparable rotator cuff deficiency. The clinical documentation submitted for review does not provide any evidence that the injured worker is not a candidate for the standard shoulder arthroplasty. Additionally, Official Disability Guidelines recommend that the injured worker have adequate deltoid function, adequate passive range of motion, with no evidence of shoulder infection or sever neurological deficiency. The clinical documentation submitted for review does not provide an adequate assessment of the injured worker's deltoid function or passive range of motion. Therefore, the need for this surgical intervention is not supported by objective findings. As such, the requested Right reverse shoulder arthroplasty is not medically necessary or appropriate.

### **1 day inpatient stay:** 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) Shoulder.

**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.

### **Surgical assistant:** 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) Shoulder.

**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.

**Post operative physical therapy times 12 visits:** 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) Shoulder.

**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.

**Pre-operative cardiac clearance:** 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) Shoulder.

**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.

**Airplane Sling:** 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) Shoulder.

**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.