

Case Number:	CM14-0085550		
Date Assigned:	07/23/2014	Date of Injury:	06/04/2007
Decision Date:	10/20/2014	UR Denial Date:	05/29/2014
Priority:	Standard	Application Received:	06/09/2014

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 Orthopaedic 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:

This 76-year-old male assistant receiver sustained an industrial injury on 6/4/07. Injury occurred when a wood crate fell off an overhead platform, landing on his head. He was knocked to the floor with immediate onset of pain in his head, neck, and left shoulder. Past surgical history was positive for heart stents x 6, angioplasty x3, and left rotator cuff repair in 2007. The 9/19/13 left shoulder MR Arthrogram impression documented post-surgical rotator cuff changes. The supraspinatus repair was diffusely attenuated in appearance measuring less than 2 mm in thickness. This particularly affected the posterior margin of the distal tendon at the screw tract and the anterior border of the myotendinous junction/muscle belly with diffuse fatty atrophy. There was a chronic partial thickness tear of the infraspinatus affecting the anterior border, focally high grade in severity with proximal atrophy. There was diffuse subscapularis tendinosis with fraying of the superior fibers. There was an extensive SLAP lesion with circumferential labral degeneration and underlying glenohumeral joint osteoarthritis. There were acromioclavicular joint degenerative changes status post subacromial decompression. The progress reports from 12/16/13 to 4/21/14 documented chronic shoulder pain improved with corticosteroid injection, which were limited to 3 per year. The 5/12/14 treating physician report indicated that the left shoulder bothers him most of the time with any reaching and at night. The patient reported no impairment in getting dressed, donning/doffing shoes and socks, doing housework, driving, or sleeping through the night. He was working as a substitute school custodian. Left shoulder exam documented obvious anterosuperior escape of the shoulder. Active and passive range of motion testing documented forward flexion 90, abduction 70, external rotation 50, and internal rotation 0 degrees. There was moderate anterior, lateral and bicipital groove pain. There was no biceps deformity or pain over the acromioclavicular joint. Instability testing documented 0 anterior, posterior and inferior translation. There was 3/5 rotator

cuff strength. There was a positive impingement test and no atrophy in the supraspinatus fossa. X-rays revealed a mildly high-riding humeral head with degenerative joint disease changes. There was mild acetabularization of the acromion and moderate acromioclavicular joint degenerative joint disease. The diagnosis was symptomatic and chronic cuff tear arthropathy, left shoulder. The treatment plan recommended a reverse total shoulder arthroplasty. The 5/29/14 utilization review denied the reverse left shoulder replacement and associated requests as there was no documentation of failed recent physical therapy or that the patient had adequate deltoid function or passive range of motion consistent with guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Reverse Left total shoulder replacement and distal clavicle excision with assistant: Upheld

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

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

Decision rationale: The California MTUS does not provide recommendations for this procedure. The Official Disability Guidelines recommend reverse shoulder arthroplasty for patients who have shoulder arthritis coupled with irreparable rotator cuff tear. The patient must meet all the following criteria: limited functional demands, intractable pain that has not responded to conservative therapy (including anti-inflammatory medications, intra-articular steroid injections and physical therapy for at least 6 months and failed), adequate range of motion to obtain functional benefit from the prosthesis, adequate deltoid function, residual bone permits firm fixation of implant, no evidence of infection, and no severe neurologic deficiency. Guideline criteria have not been met. Evidence of 6-months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, including physical therapy and anti-inflammatories, and failure has not been submitted. There is improvement documented with corticosteroid injections. Significant limitation in activities of daily living is not documented. Current range of motion findings document marked loss of active and passive range of motion of the left shoulder. There is significant rotator cuff weakness and no indication of adequate deltoid function. Therefore, this request is not medically necessary.

1 day inpatient stay: Upheld

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

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-op clearance: Upheld

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

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.

DME ultra sling: Upheld

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

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-op physical therapy 2-3 x a week for 6 weeks for a total of 18 visits: Upheld

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

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.