

Case Number:	CM14-0142741		
Date Assigned:	09/10/2014	Date of Injury:	05/22/2014
Decision Date:	04/07/2015	UR Denial Date:	08/04/2014
Priority:	Standard	Application Received:	09/03/2014

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. 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: Minnesota, Florida
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 66-year-old male, who sustained an industrial injury on 5/22/2014. He sustained a large rotator cuff tear of the left shoulder with retraction and atrophy. Treatment to date has included modified activity, diagnostic imaging and medications. Magnetic resonance imaging (MRI) of the left shoulder dated 6/05/2014 revealed the large full thickness rotator cuff tear with 4 cm retraction, and superior subluxation of the humeral head. Currently, the IW complains of left shoulder pain described as burning, aching and sharp. Objective findings included moderate atrophy in the supraspinatus and infraspinatus. There is moderate crepitus in the subacromial space. Active range of motion is elevation 30, flexion 30 and ER is severely limited. Passive range of motion is elevation 170, flexion slightly decreased and ER slightly decreased. Strength is severely limited. Drop arm sign, subscapularis liftoff test and empty can test are all positive. On 08/04/2014 Utilization Review non-certified a request for left shoulder total arthroplasty, reverse prosthesis, assistant surgeon and inpatient stay noting that the clinical information submitted for review fails to meet the evidence based guidelines for the requested service. The MTUS, ACOEM Guidelines, (or ODG) was cited. On 9/03/2014, the injured worker submitted an application for IMR for review of left shoulder total arthroplasty, reverse prosthesis, assistant surgeon and inpatient stay.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left total shoulder arthroplasty, reverse prosthesis, Quantity 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Orthop Clin North Am 2013 Jul;44(3):389-408, x 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, Section: Shoulder, Topic: Reverse shoulder arthroplasty.

Decision rationale: Reverse shoulder arthroplasty is recommended for people who have shoulder arthritis coupled with an irreparable rotator cuff tear and it is also performed for patients with very complex shoulder problems including those with failed previous surgical treatments. It is a new form of shoulder replacement approved by the FDA in 2004. It involves the insertion of a hemispherical implant in place of the glenoid and the cup section is added to the humerus allowing the arm to be moved primarily by the deltoid instead of the rotator cuff. The ODG indications for surgery include nonfunctioning irreparable rotator cuff plus glenohumeral arthropathy and multiple other indications for fractures, failed hemiarthroplasty, etc. The following criteria must be met: Limited functional demands and intractable pain that has not responded to conservative therapy and physical therapy for at least 6 months and failed and adequate deltoid function and adequate passive range of motion, and residual bone permits firm fixation of the implant, no evidence of shoulder infection, and no severe neurologic deficiency. The injured worker has a complete rotator cuff tear with retraction and superior subluxation of the humeral head but there is only minimal narrowing of the glenohumeral joint space, no significant osteoarthritis, and no prior issues with the shoulder. The guideline requirement of glenohumeral arthritis has not been met. There has not been any conservative treatment and the rotator cuff has not been repaired/failed. In light of the above, the ODG criteria have not been met and as such, the request for a reverse shoulder arthroplasty is not supported and the medical necessity is not established.

Assistant Surgeon, Quantity 1: 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.

Inpatient Stay x 2 days: 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.