

Case Number:	CM15-0003852		
Date Assigned:	01/14/2015	Date of Injury:	06/14/2010
Decision Date:	03/17/2015	UR Denial Date:	12/27/2014
Priority:	Standard	Application Received:	01/08/2015

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: California
 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 65 year old male, who sustained an industrial injury on 6/14/10. He has reported right shoulder pain. The diagnoses have included localized primary osteoarthritis of the shoulder region, traumatic arthropathy, joint ankyloses of shoulder, shoulder pain, adhesive capsulitis of shoulder disorder of bursa of shoulder region, ganglion/synovial cyst of shoulder, Glenoid labrum detachment and sprain of shoulder and upper arm. Treatment to date has included right revision total screw arthroplasty, arthroscopic debridement times 2, physical therapy and mediations. Currently, the IW complains of persistent right greater than left shoulder pain. Physical exam performed on 11/14/14 revealed painful range of motion and mild crepitus. The impression was chronic cuff arthropathy in a patient with a failed total shoulder replacement. On 12/27/14 Utilization Review non-certified a reconstruction of shoulder joint and inpatient stay, noting the lack of information as to why the physician would feel this surgery would be appropriate. The ODG was cited. On 1/5/15, the injured worker submitted an application for IMR for review of reconstruction of shoulder joint and inpatient stay.

IMR ISSUES, DECISIONS AND RATIONALES

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

Reverse Total with Removal-23472 of the right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Indications for Surgery--Reverse Shoulder Arthroplasty

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder section, Arthroplasty

Decision rationale: CA MTUS/ACOEM is silent on this issue of shoulder replacement. According to the ODG Shoulder section, arthroplasty "The most common indication for total shoulder arthroplasty is osteoarthritis, but for hemiarthroplasty it is acute fracture. There was a high rate of satisfactory or excellent results after total shoulder arthroplasty for osteoarthritis, but hemiarthroplasty offered less satisfactory results, most likely related to the use of this procedure for trauma." Shoulder arthroplasty is indicated for glenohumeral and acromioclavicular osteoarthritis with severe pain with positive radiographic findings and failure of 6 months of conservative care. In this case there is insufficient evidence in the records of 11/14/14 of failure of conservative care. Therefore, the determination is for non-certification.

Associated Surgical Service: 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder, Hospital length of stay

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