

Case Number:	CM15-0018390		
Date Assigned:	02/06/2015	Date of Injury:	04/16/2012
Decision Date:	04/07/2015	UR Denial Date:	01/09/2015
Priority:	Standard	Application Received:	01/30/2015

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 52 year old female, who sustained an industrial injury on 4/16/2012. On 1/30/15, the injured worker submitted an application for IMR for review of Right shoulder arthroplasty verses a total reverse arthroplasty, and Physical Therapy x12 and arm sling and cold therapy unit rental for 7 days. The treating provider has reported the injured worker is contemplating another right shoulder surgery. Exam note 1/6/15 demonstrates right shoulder pain. Exam demonstrates right shoulder forward flexion to 100 degrees, abduction to 100 degrees. Report states that the patient has end stage arthritis of the right shoulder and has had 4 prior rotator cuff and labral surgeries. The diagnoses have included osteoarthritis involving shoulder region. Treatment to date has included status post right shoulder surgery (1/21/13), physical therapy for right shoulder post-operatively (x29), right shoulder injections, TENs, Unit, MRI right shoulder (5/15/12). On 1/9/15 Utilization Review non-certified Right shoulder arthroplasty verses a total reverse arthroplasty, and Physical Therapy x12 and arm sling and cold therapy unit rental for 7 days. The MTUS Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroplasty vs total reverse arthroplasty: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, 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 traum. 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 a recent MRI of the right shoulder. This is important preoperative test to obtain prior to decision for a shoulder versus reverse shoulder arthroplasty. In addition while the exam note from 1/6/15 demonstrates report of end stage arthritis of the shoulder, no formal radiographic report is present in the records. Therefore the determination is for non-certification.

Associated Surgical Service 12 sessions of Physical Therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26-27.

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

Associated Surgical Service: arm sling: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines- Immobilization.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

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

Associated Surgical Service cold therapy unit rental for 7 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, Continuous flow cryotherapy.

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