

Case Number:	CM15-0019449		
Date Assigned:	02/09/2015	Date of Injury:	04/16/2012
Decision Date:	04/01/2015	UR Denial Date:	01/09/2015
Priority:	Standard	Application Received:	02/03/2015

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, Sports Medicine

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 reported an injury on 04/16/2012. The mechanism of injury was not specifically stated. The current diagnosis is end stage arthritis of the right shoulder. The injured worker presented on 01/06/2015 for a follow up evaluation. It was noted that the injured worker was status post 2 corticosteroid injections. The injured worker had also been previously treated with up to 24 sessions of physical therapy. Upon examination, there was 100 degree forward flexion, 100 degree abduction, 20 degree internal rotation, and 70 degree external rotation. There was 4/5 supraspinatus weakness with positive Neer's and Hawkins maneuvers and positive AC cross body compression test. Right shoulder x-rays were obtained in the office on that date, and revealed right shoulder glenohumeral joint bone on bone inferiorly with a large spur. Recommendations at that time included a right total shoulder replacement versus right total shoulder reverse with a postoperative cold therapy rental for 7 days, postoperative physical therapy, and an assistant surgeon. A Request for Authorization Form was submitted on 01/06/2015.

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.

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

Decision rationale: The Official Disability Guidelines recommend a shoulder arthropathy for glenohumeral and acromioclavicular joint osteoarthritis, post traumatic arthritis, or rheumatoid arthritis. In this case, it was noted that the injured worker had been previously treated with steroid injections and physical therapy. However, there were no imaging studies provided for this review. It was noted on the requesting date of 01/06/2015 the injured worker's MRI revealed advanced arthritis; however, the official imaging study was not provided for this review. The injured worker was initially treated postoperatively in 2012, with 2 steroid injections and physical therapy; however, there was no mention of a recent attempt at any conservative treatment to include active rehabilitation. Given the above, the medical necessity has not been established at this time. Therefore, the request is not medically appropriate.

Associated Surgical Service: 12 sessions of Physical therapy: Upheld

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

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.

Associated Surgical Service: Arm sling (purchase): Upheld

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

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.

Associated Surgical Service: Cold therapy (rental 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- Continuous-flow cryotherapy.

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.