

Case Number:	CM15-0188255		
Date Assigned:	09/30/2015	Date of Injury:	02/10/2015
Decision Date:	12/08/2015	UR Denial Date:	09/23/2015
Priority:	Standard	Application Received:	09/24/2015

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, Indiana, Oregon 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 63-year-old male who sustained an industrial injury on 2-10-15. A review of the medical records indicates he is undergoing treatment for left shoulder rotator cuff atrophy with superior migration of the humeral head, persistent weakness, rotator cuff arthropathy, and superior migration of the humeral head. Medical records (5-5-15 to 8-7-15) indicate ongoing complaints of left shoulder pain and weakness. On 6-12-15, he reported that he "believes his shoulder strength has worsened". The records state that the injured worker had a "preexisting atrophy in his rotator cuff prior to his work injury", but "noticed significant worsening of his weakness and pain after the injury". The physical exam (8-7-15) reveals diminished range of motion in the cervical spine and left shoulder. Mild soft tissue swelling is noted of the left shoulder with moderate tenderness over the anterior rotator cuff and proximal biceps. Pain is noted on "terminal flexion and terminal abduction". Positive "drop-arm sign, Jobe's sign, and Hawk's sign" is noted. Strength is "4 out of 5" on abduction, "4 out of 5" on external rotation, "5 out of 5" on internal rotation, and "4 out of 5" on forward flexion. "Normal" sensation is noted. Diagnostic studies have included an MRI of the left shoulder. Treatment has included medications, modified activity, and physical therapy. Additional physical therapy requests have been denied. The treatment recommendation is for reverse shoulder arthroplasty "to treat his pain, dysfunction, and rotator cuff arthropathy." The utilization review (9-23-15) includes requests for authorization for left shoulder reverse arthroplasty, assistant surgeon, postoperative left shoulder physical therapy x 12 visits, Ultram 150mg #30, preoperative medical clearance, preoperative EKG, and preoperative chest x-ray. All requests were denied.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left shoulder reverse arthroplasty: Upheld

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

Decision rationale: CA MTUS/ACOEM is silent on this issue of shoulder replacement. According to the ODG Shoulder section, 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 evidence of a massive rotator cuff tear, but no arthritis on the MRI. The request does not conform with guideline recommendations and is not medically necessary.

Associates surgical service: Assistant surgeon: 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-operative physical therapy for the left shoulder, 12 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.

Pre-operative medical 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.

Pre-operative Electrocardiogram (EKG): 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-operative chest X-ray: 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.

Ultram 150mg, #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: Per the CA MTUS Chronic Pain Medical Treatment Guidelines pages 93-94, Tramadol is a synthetic opioid affecting the central nervous system. Tramadol is indicated for moderate to severe pain. Tramadol is considered a second line agent when first line agents such as NSAIDs fail. There is insufficient evidence in the records of failure of primary over the counter non-steroids or moderate to severe pain to warrant Tramadol. Therefore, use of Tramadol is not medically necessary.