

Case Number:	CM15-0196235		
Date Assigned:	10/09/2015	Date of Injury:	06/13/2014
Decision Date:	12/28/2015	UR Denial Date:	10/02/2015
Priority:	Standard	Application Received:	10/06/2015

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 74 year old male with an industrial injury dated 06-13-2014. A review of the medical records indicates that the injured worker is undergoing treatment for right shoulder cuff tear arthropathy. In a progress report dated 05-06-2015, the treating physician reported positive crepitation, positive Hawkins, positive stiffness and pain with range of motion of the right shoulder. Several documents within the submitted medical records are difficult to decipher. According to the progress note dated 08-22-2015, the injured worker reported chronic right shoulder pain and difficulty with function and activity. Pain level was not included in report. Objective findings (08-22-2015) revealed pseudoparalysis of right shoulder, active flexion and extension of 70 degrees, positive Horn blowers sign, and 130 degrees passive range of motion. The treating physician reported that X-rays and MRI revealed rotator cuff arthropathy with retracted cuff tear with atrophy and cephalad migration, humeral head and osteoarthritis. Magnetic Resonance Imaging (MRI) Report of the right shoulder dated 03-20-2013 revealed "complete tear of the supraspinatus and infraspinatus tendons with medial retraction near the level of the glenoid, as well as large full, thickness tear of the subscapularis tendon. There was severe atrophy of the supraspinatus and infraspinatus muscles and tendonosis of the biceps tendon. High riding humeral head due to rotator cuff tear, with contact between the humeral head and acromion. There was moderate chondral thinning within the glenohumeral joint. Moderate sized glenohumeral joint effusion and free communication of joint fluid into the subacromial- subdeltoid and subcoracoid bursae via the rotator cuff tear. There were moderate degenerative changes of the acromioclavicular joint." Treatment has included diagnostic studies, prescribe medications, physical therapy, activity modification with symptomatic relief and

periodic follow up visits. The treatment plan included reverse total shoulder surgery. The treating physician prescribed services for reverse total shoulder surgery, right shoulder, associated surgical service: Inpatient stay Qty 3, Pre-op medical clearance Qty 1, associated surgical service: home health physical 2 weeks post-op, right shoulder Qty 1, post-op physical therapy twice weekly, right shoulder Qty 12 and cold compress unit Qty 1. The utilization review dated 10-02-2015, non-certified the request for reverse total shoulder surgery, right shoulder, associated surgical service: Inpatient stay Qty 3, Pre-op medical clearance Qty 1, associated surgical service: home health physical 2 weeks post-op, right shoulder Qty 1, post-op physical therapy twice weekly, right shoulder Qty 12 and cold compress unit Qty 1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Reverse total shoulder surgery, right shoulder: Upheld

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

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 failure of conservative care including recent physical therapy or response to injection. The MRI reveals only cartilage thinning without high grade changes. Therefore the request is not medically necessary.

Associated surgical service: Inpatient stay Qty 3: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Hospital length of stay (LOS).

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

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Pre-op medical clearance Qty 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.guidelines.gov/content>.

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

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Associated surgical service: Home health physical 2 weeks post-op, right shoulder Qty 1: Upheld

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

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

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Post-op physical therapy twice weekly, right shoulder Qty 12: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

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

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.

Cold compress Unit Qty 1: 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 base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder.

Decision rationale: As the requested surgical procedure is not medically necessary, none of the associated services are medically necessary and appropriate.