

<b>Case Number:</b>	CM15-0202037		
<b>Date Assigned:</b>	10/16/2015	<b>Date of Injury:</b>	07/10/2014
<b>Decision Date:</b>	12/03/2015	<b>UR Denial Date:</b>	10/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2015

### 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: Tennessee, Florida, Ohio  
 Certification(s)/Specialty: Surgery, Surgical Critical Care

### 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 66 year old male who sustained an industrial injury on 07-10-2014. A review of the medical records indicated that the injured worker is undergoing treatment for degenerative arthropathy of the left shoulder. According to the treating physician's progress report on 09-21-2015, the injured worker continues to experience left shoulder pain and stiffness rated at 8-9 out of 10 at times. Examination demonstrated no deformity, no redness, and no warmth with neurovascular status intact. Range of motion was noted as forward flexion at 100 degrees, abduction at 90 degrees and external rotation at 10 degrees. There was good strength with abduction, external rotation and belly press with bony crepitus through range of motion. An official report of left shoulder magnetic resonance imaging (MRI) performed on 09-10-2015 was included in the review and interpreted by the provider on 09-21-2015 as "rotator cuff intact, bone on bone arthritis with inferior spurs and osteophytes and no deformity at the glenoid." Prior treatments have included diagnostic testing and medications. Current medications were not noted. On 09-23-2015 the provider requested authorization for total left shoulder replacement, pre-operative laboratory blood work, chest X-ray, Electrocardiogram (EKG), home health and post-operative physical therapy #8. On 10-03-2015 the Utilization Review determined the requests for total left shoulder replacement, pre-operative laboratory blood work, chest X-ray, Electrocardiogram (EKG), home health and post-operative physical therapy #8 were not medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Total Left Shoulder Replacement: 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).

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

**Decision rationale:** There is sufficient clinical information provided to justify the medical necessity of this request for this patient. The patient's medical records support the fact that he has chronic shoulder osteoarthritis with clinically subjective and objective findings to support this diagnosis. Functional pain assessment using a visual scale confirmed intractable pain rated 8- 9/10. The patient lacked any severe neurological deficiency or evidence of septic joint that would require immediate surgical care. MTUS and ACOEM do not address this topic. Per ODG guidelines, this patient does not meet criteria for total shoulder arthroplasty. This patient has a glenohumeral arthropathy which is demonstrable on physical exam and radiographic imaging. However, he does not meet ODG criteria for surgery because he has not been documented to have failed greater than six months of physical therapy or any other conservative measures, including NSAIDS and steroid injections. Therefore, based on the submitted medical documentation, the request for total left shoulder replacement is not medically necessary.

**Pre-Operative: Labs: 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 Official Disability Guidelines (ODG) pre-operative testing.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of the requested test for this patient. The California MTUS guidelines and the ACOEM Guidelines do not address this topic. According to the Official Disability Guidelines (ODG), pre-operative medical clearance is: "Preoperative additional tests are excessively ordered, even for young patients with low surgical risk, with little or no interference in perioperative management." This patient has been requested to receive multiple labs and tests in anticipation of surgery. The patient's surgery has not been approved and thus the requested tests are not indicated. Therefore, based on the submitted medical documentation, the request for pre-op labs is not-medically necessary.

**Pre-Operative: EKG: 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 Official Disability Guidelines (ODG) Preoperative Lab Testing.

**Decision rationale:** There is insufficient clinical information provided to justify the medical necessity of EKG testing for this patient. The California MTUS guidelines and the ACOEM Guidelines do not address the topic of preoperative lab testing. According to the Official Disability Guidelines (ODG), pre-operative EKG is: "Necessary for patients undergoing high or intermediate risk surgical procedures." The surgery for this patient has not been approved. Therefore, the testing cannot be approved. Thus, based on the submitted medical documentation, medical necessity for EKG testing has not been established.

**Pre-Op: CXR:** 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 Official Disability Guidelines (ODG) Pulmonary (Acute & Chronic), Chest X-ray.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of a chest x-ray for this patient. The clinical records submitted do not support the fact that this patient has been documented to have signs or symptoms of chronic lung disease requiring radiographic imaging. The California MTUS guidelines and the ACOEM Guidelines do not address the topic of CXR testing. Per the Occupational Disability Guidelines (ODG), a chest x-ray is "Recommended if acute cardiopulmonary findings by history/physical, or chronic cardiopulmonary disease in the elderly (> 65). Routine chest radiographs are not recommended in asymptomatic patients with unremarkable history and physical." This patient's surgery has been denied. Therefore, the testing has also been denied. Therefore, based on the submitted medical documentation, the request for chest x-ray is not-medically necessary. Reference: ODG, Pulmonary (Acute & Chronic), Chest X-ray

**Post-Operative Physical Therapy #8:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Follow-up Visits, Surgical Considerations.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of this order for this patient. The California MTUS guidelines and the ACOEM Guidelines do address the topic of physical therapy for the shoulder. The guidelines state that physical therapy is "Recommended generally if there is a medical need" post-operatively. This patient's request for surgery is not authorized. Therefore, a need for the requested post-op physical therapy does not exist. Therefore, based on the submitted medical documentation, the request for postoperative physical therapy is not medically necessary.

**Home Health:** 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).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Home health services.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of a Home Health RN for this patient. The clinical records submitted do not support the fact that this patient would require Home Health nursing services for no more than 35 hours per week. The California MTUS Guidelines state that Home Health Services are recommended only for medical treatment of "patients who are homebound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week." Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. This patient has not been authorized to receive surgery; therefore they do not require a skilled nursing level of care. Therefore, based on the submitted medical documentation, the request for a home health is not medically necessary.