

<b>Case Number:</b>	CM15-0218150		
<b>Date Assigned:</b>	11/10/2015	<b>Date of Injury:</b>	04/02/2014
<b>Decision Date:</b>	12/21/2015	<b>UR Denial Date:</b>	10/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/05/2015

### 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: Illinois, California, Texas  
 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:

This injured worker is a 58-year-old male who sustained an industrial injury on 4/02/14. Injury occurred relative to a slip and fall directly onto the right shoulder. Past surgical history was positive for right shoulder rotator cuff surgery in 2007, right shoulder replacement in 2007, lumbar laminectomy, and left total shoulder replacement in 2010. The 5/12/14 right shoulder CT scan impression documented total shoulder arthroplasty in satisfactory alignment with no evidence of periprosthetic fracture or definite lucency. There was no evidence of acute fracture or injury. The 8/6/15 medical legal report documented constant grade 6-7/10 right shoulder pain that increased to a severe level with lifting, pushing, pulling or using the steering wheel. Conservative treatment had included medications, activity modification, physical therapy, home exercise, and acupuncture. Right shoulder exam documented no tenderness to palpation and symmetrical normal musculature. Range of motion was symmetrical with flexion 110, extension 30, abduction 70, and adduction 30 degrees. External rotation was 50 degrees right and 70 left, and internal rotation was 20 right and 60 left. Shoulder strength testing documented supraspinatus 3/5 bilaterally, external rotation 5-/5 right and 4-5/ left, deltoid 3/5 bilaterally, and subscapularis 5-/5 bilaterally. Orthopedic testing of the shoulders was negative bilaterally. Future medical treatment was recommended to include conservative treatment of the right shoulder. There were no work restrictions required. The 8/24/15 treating physician report cited grade 7/10 right shoulder pain on a day to day basis. Right shoulder active forward flexion was 120 degrees and external rotation to 40 degrees. X-rays and CT scan showed stable implants. The injured worker had right shoulder pain and had failed conservative management. Authorization was requested for right total shoulder arthroplasty revision reverse total shoulder arthroplasty. The 10/29/15 utilization review non-certified the request for right total shoulder arthroplasty revision reverse total shoulder

arthroscopy as there was no detailed evidence of conservative treatment failure and surgical criteria had not been met relative to documentation of adequate deltoid function, adequate passive range of motion to obtain functional benefit from the prosthesis, residual bone permits firm fixation of the implant, no evidence of shoulder injection, and no severe neurologic deficiency.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Right total shoulder arthroplasty revision reverse total shoulder arthroplasty:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-Shoulder (Acute and Chronic): 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: Arthroplasty; Reverse shoulder arthroplasty.

**Decision rationale:** The California MTUS does not provide recommendations for this procedure. The Official Disability Guidelines recommend arthroplasty for selected patients. Surgical indications include glenohumeral or acromioclavicular joint osteoarthritis with severe pain preventing a good night's sleep or functional disability that interferes with activities of daily living or work, positive radiographic findings of shoulder joint degeneration, and failure of at least 6 months of conservative treatment. For reverse arthroplasty, the patient must meet all the following criteria: limited functional demands, intractable pain that has not responded to conservative therapy (including anti-inflammatory medications, intra-articular steroid injections and physical therapy for at least 6 months and failed), adequate range of motion to obtain functional benefit from the prosthesis, adequate deltoid function, residual bone permits firm fixation of implant, no evidence of infection, and no severe neurologic deficiency. Guideline criteria have not been met. This injured worker presents status post right total shoulder arthroplasty having sustained a fall onto the shoulder. He has constant right shoulder pain, increased with lifting, pushing, pulling, and using a steering wheel. Clinical exams documented significant loss of range of motion and deltoid weakness. Imaging did not evidence any hardware failure, loosening, or breakage. Detailed evidence of up to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial, including injection, and failure has not been submitted. There is no documentation relative to the condition of the residual bone to permit firm fixation of the implant. Therefore, this request is not medically necessary at this time.