

Case Number:	CM15-0043652		
Date Assigned:	03/13/2015	Date of Injury:	11/01/2012
Decision Date:	05/01/2015	UR Denial Date:	02/10/2015
Priority:	Standard	Application Received:	03/09/2015

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: Minnesota, Florida
 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 71 year old male who sustained an industrial injury on 11/01/2012. Diagnoses include massive rotator cuff tear with cuff tear arthropathy. There were no previous treatments listed in the documents reviewed. A physician progress note dated 01/20/2015 documents the injured worker has continued pain in his left shoulder, and has limited range of motion. On examination left shoulder elevation is about 90 degrees, and on the right side about 140 degrees. He has external rotation of 30 on the left and 50 on the right. He has a positive Neer and Hawkins impingement sign tests. On 02/03/2015 the injured worker returned for reevaluation of his left shoulder due to significant pain and limitation of movement. Treatment requested is for 12 initial post-operative physical therapy 2x6 weeks for the left shoulder, One (1) CT scan 2D/3D for the left shoulder, One (1) cold unit-7 day rental/purchase, One (1) left reverse total shoulder arthroplasty (inpatient/outpatient not specified) with assistant surgeon, and One (1) medical clearance.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) left reverse total shoulder arthroplasty (inpatient/outpatient not specified) with assistant surgeon: 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); Section: Shoulder, Topic: Reverse shoulder arthroplasty.

Decision rationale: ODG criteria for reverse shoulder arthroplasty include nonfunctioning irreparable rotator cuff and glenohumeral arthropathy with limited functional demands and intractable pain that has not responded to conservative therapy including NSAIDs, intra-articular steroid injections and physical therapy for at least 6 months and failed, and adequate deltoid function, adequate passive range of motion to obtain functional benefit, and absence of shoulder infection or neurologic deficit. The documentation from January 20, 2015 indicates that this IW was last seen a year ago. He was continuing to experience shoulder pain worse with activity and had limitation of motion. On examination left shoulder elevation was 90 and right shoulder elevation 140. External rotation was 15 on the left and 15 on the right. Internal rotation was to L3 on the left and T12 on the right. Strength was 3+/5 in the infraspinatus and 5/5 in the subscapularis. There was tenderness to palpation over the greater tuberosity as well as over the glenohumeral joint. External rotation lag test and Neer and Hawkins impingement signs were positive. The prior MRI study showed a massive rotator cuff tear with arthropathy. A reverse shoulder arthroplasty was recommended. The documentation submitted does not include evidence of conservative therapy including NSAIDs, intra-articular steroid injections and physical therapy for at least 6 months prior to the surgery. No such rehabilitation program has been documented in the last 6 months. As such, the request for a reverse shoulder arthroplasty of the left shoulder is not supported by guidelines, and the medical necessity of the request has not been substantiated. Since the primary surgical procedure is not medically necessary, the request for an assistant surgeon is also not medically necessary.

One (1) CT scan 2D/3D for the left 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 (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Section: Shoulder, Topic: Reverse shoulder arthroplasty.

Decision rationale: Since the primary procedure is not medically necessary, the associated pre-operative CT scan is also not medically necessary.

One (1) medical clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Merck Manual.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Section: Shoulder, Topic: Reverse shoulder arthroplasty.

Decision rationale: The requested surgery is not medically necessary. Therefore the request for medical clearance is also not medically necessary.

One (1) cold unit-7 day rental/purchase: 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); Section: Shoulder, Topic: Reverse shoulder arthroplasty.

Decision rationale: The requested surgical procedure is not medically necessary. Therefore the ancillary services are also not medically necessary.

12 initial post-operative physical therapy 2x6 weeks for the left shoulder: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Section: Shoulder, Topic: Reverse shoulder arthroplasty.

Decision rationale: The requested surgical procedure is not medically necessary. Therefore the ancillary services are also not medically necessary.