

<b>Case Number:</b>	CM15-0059763		
<b>Date Assigned:</b>	04/06/2015	<b>Date of Injury:</b>	08/20/2010
<b>Decision Date:</b>	05/29/2015	<b>UR Denial Date:</b>	03/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/30/2015

### 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  
 Certification(s)/Specialty: Orthopedic Surgery, Sports Medicine

### 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 62-year-old female, who sustained an industrial injury on 08/20/2010. Diagnoses included osteoarthritis right shoulder. Treatment to date has included radiographic imaging, two shoulder surgeries and medications. The injured worker presented on 02/19/2015 for a follow-up evaluation regarding right shoulder pain. The injured worker stated, she was picking up a dog to place him in the bathtub and felt a pulling sensation in the right shoulder. The injured worker had a prior rotator cuff repair completed on 06/06/2011. The pain increased and the injured worker underwent an additional surgery on 12/06/2011 by the same surgeon. The injured worker reported painful and limited range of motion with an inability to hold on to objects. Upon examination, there was tenderness to palpation over the anterior and posterior right shoulder, 40 degrees flexion, 40 degrees abduction, 15 degrees external rotation, 0 degree internal rotation, 5/5 motor strength, and negative orthopedic testing. X-rays of the glenohumeral and AC joint were completed in the office, which revealed moderate to advanced rotator cuff arthropathy in the right shoulder. Treatment recommendations at that time included a partial versus a reverse shoulder replacement with a postoperative course of rehabilitation. There was no request for authorization form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

### **Shoulder Hemiarthroplasty: 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) Shoulder Chapter, Arthroplasty (shoulder).

**Decision rationale:** The Official Disability Guidelines recommend a shoulder arthroplasty if there is evidence of glenohumeral and acromioclavicular joint osteoarthritis, post-traumatic arthritis or rheumatoid arthritis. There should be evidence of severe pain or functional disability interfering with activities of daily living, positive radiographic findings and an exhaustion of conservative therapy to include NSAIDs, steroid injections, and physical therapy for at least 6 months. In this case, there is no documentation of a recent attempt at any conservative management in the form of active rehabilitation or an intra-articular steroid injection. There were no official imaging studies provided for review. The request as submitted did not specify whether the shoulder hemiarthroplasty was for the left or right side. Given the above, the request is not medically necessary at this time.

### **Pre-Operative EKG and Lab: 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.

### **Associated Surgical Service: Crutches: 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 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.

**Associated Surgical Service: Physical Therapy (12-sessions, 2 times a week for 6 weeks):**  
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.