

Case Number:	CM14-0168851		
Date Assigned:	10/16/2014	Date of Injury:	08/31/1994
Decision Date:	11/18/2014	UR Denial Date:	10/03/2014
Priority:	Standard	Application Received:	10/13/2014

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. The expert reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in Indiana. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 73-year-old female employee for a school district with a date of injury of 8/31/94. The carrier has accepted the neck and bilateral upper extremities. The worker had an MRI of the right shoulder performed on 7/8/97 that revealed a complete tear of the supraspinatus tendon, an EMG/NCV performed on 3/19/98 that was normal, and an MRI of the right shoulder performed on 7/10/14 that revealed a chronic full thickness tear with high-riding humeral head and advanced muscular denervation. X-rays of the right shoulder taken on 6/9/14 were read as revealing narrowing of the subacromial space and mild to moderate arthritic changes of the glenohumeral joint. The worker underwent surgery on her right shoulder on 11/04/97 for an arthroscopic subacromial decompression, release of the coracoacromial ligament, and mini-open rotator cuff repair; and on 6/11/98 for arthroscopic lysis of adhesions, manipulation under anesthesia and arthroscopic rotator cuff repair of the right shoulder. On 7/21/14 the treating physician complained of right shoulder pain at night and which inhibited her daily activities. She had difficulty reaching or lifting anything at or above shoulder level. On physical exam the worker had active elevation of the right shoulder to 90 degrees with pain and breaks easily with light resistance, good rotational strength, good abduction strength at 90 degrees, total elevation of 120 degrees, and complained of pain with all reaching and lifting activities. The impression was s/p right rotator cuff repair with right shoulder arthritis and rotator cuff arthropathy. The worker is on Percocet for pain relief. The treating physician has requested approval for a reverse right total shoulder replacement, a 2-day inpatient hospital stay, post-operative physical therapy for a total of 12 visits, a post-operative sling, and a post-operative polar care unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Total shoulder replacement, right shoulder QTY: 1.00: 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, Reverse Shoulder Arthroplasty and Arthroplasty (Shoulder)

Decision rationale: According to the ODG shoulder guidelines, a reverse shoulder arthroplasty (a type of shoulder arthroplasty recommended by the treating physician) is recommended as indicated below. Reverse shoulder arthroplasty is often used for people who have shoulder arthritis coupled with an irreparable rotator cuff tear, and it is also performed for patients with very complex shoulder problems, including those with failed previous surgical treatments. It is a newer type of shoulder replacement developed in Europe in the 1980s and approved by the FDA in 2004. It involves the insertion of a hemispherical implant in place of the glenoid instead of the humerus and the cup section being added to the humerus, allowing the arm to be moved primarily by the deltoid instead of the rotator cuff. Early results are encouraging, but not all shoulder surgeons have experience in reverse shoulder replacement. The reverse shoulder arthroplasty prosthesis was originally designed for rotator cuff arthropathy, and provided good results. The specific indications for reverse shoulder arthroplasty are noted below: ODG Indications for Surgery Reverse Shoulder Arthroplasty: Non-functioning irreparable rotator cuff and glenohumeral arthropathy; or Failed hemiarthroplasty or failed total shoulder arthroplasty with irreparable rotator deficiency; or Comminuted fractures (3 or 4 part) of the proximal humerus in an older population (65 years of age or older). And meet all of the following criteria: Limited functional demands; & 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); & 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 infection; & No severe neurologic deficiency. The injured worker does not meet the first indication for a Reverse Shoulder Arthroplasty: a Non-functioning irreparable rotator cuff. The physical exam of the right shoulder performed on 7/21/14 by the treating physician indicates that the rotator cuff is intact as the worker had good rotational strength and good abduction strength. Therefore, although the MRI of the right shoulder reveals a rotator cuff tear, it is not non-functioning and therefore the worker does not meet the guidelines for a reverse total shoulder arthroplasty and the request is not medically necessary. The indications for a Shoulder Arthroplasty are as follows: ODG Indications for Surgery Shoulder Arthroplasty: A. Glenohumeral and acromioclavicular joint osteoarthritis, post-traumatic arthritis, or rheumatoid arthritis with all of the following: 1. Severe pain (preventing a good night's sleep) or functional disability that interferes with activities of daily living or work; & 2. Positive radiographic findings (e.g., shoulder joint degeneration, severe joint space stenosis); & 3. Conservative therapies (including NSAIDs, intra-articular steroid injections, and physical therapy) have been tried for at least 6 months and failed; & 4. If rheumatoid arthritis only, tried and failed anti-cytokine agents or disease modifying anti-rheumatic drugs; B. Treatment of proximal humeral fracture nonunion, malunion, or avascular necrosis C. Not recommended if irreparable rotator

cuff tear, in young individuals or in individuals with active local or systemic infection. In this worker's case, there is no documentation in the medical records provided for review that the worker has failed at least 6 months of conservative therapies. Therefore the guidelines for a shoulder arthroplasty have not been met and the requested treatment is not medically necessary.

Inpatient stay (xdays): 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) ; ODG-TWC; ODG Treatment; Integrated Treatment /Disability Duration Guidelines, Shoulder Chapter;

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

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-operative physical therapy, right 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) Shoulder (Acute & Chronic), Reverse Shoulder Arthroplasty

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Post-operative: Sling: 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)- TWC. ODG Treatment; Integrated Treatment/Disability Duration Guidelines, Shoulder chapter; regarding sling/abduction pillow

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: Polar Care Unit: 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- TWC. ODG Treatment; Integrated Treatment/Disability Duration Guidelines, Shoulder chapter;

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.

