

Case Number:	CM14-0213385		
Date Assigned:	12/30/2014	Date of Injury:	07/05/1977
Decision Date:	02/23/2015	UR Denial Date:	11/20/2014
Priority:	Standard	Application Received:	12/19/2014

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. 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, Tennessee, South Carolina
 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:

According to the records made available for review, this is a 62-year-old male with a 7/5/77 date of injury. At the time (10/14/14) of request for authorization for 1 Total shoulder replacement: left shoulder first then right shoulder 2 months later between 10/23/2014 and 1/25/2015, associated surgical services: 1 medical clearance w/ internal Medical Associates, associated surgical services: 1 day inpatient hospital stay between 10/23/2014 and 1/25/2015, associated surgical services: 1 Ultra Sling between 10/23/2014 and 1/25/2015, associated surgical services: 1 TENS unit between 10/23/2014 and 1/25/2015, associated surgical services: 2 Weeks rental-Vascutherm unit between 10/23/2014 and 1/25/2015, and associated surgical services: 18 Sessions of post-op physical therapy between 10/23/2014 and 1/25/2015, there is documentation of subjective (severe bilateral shoulder pain resulting to difficulty in sleeping) and objective (decrease range of motion with pain, crepitus, tenderness over the bicipital groove, no pain over the acromioclavicular joint, 4/5 strength of supraspinatus and infraspinatus, positive impingement sign) findings, imaging findings (X-ray of the bilateral shoulders (undated) report revealed severe osteoarthritis with concentric wear), current diagnoses (bilateral shoulder arthritis), and treatment to date (medications, physical therapy, and cortisone injections). Regarding 1 Total shoulder replacement, left shoulder first then right shoulder 2 months later between 10/23/2014 and 1/25/2015, there is no documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Total shoulder replacement: left shoulder first then right shoulder 2 months later between 10/23/2014 and 1/25/2015: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Indications for Surgery- Shoulder Arthroplasty

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-11. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Arthroplasty (shoulder).

Decision rationale: MTUS reference to ACOEM guidelines support surgical consultation/intervention for patients who have: Red flag conditions; Activity limitation for more than four months, plus existence of a surgical lesion; Failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion; Clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long-term, from surgical repair. ODG identifies documentation of Glenohumeral and acromioclavicular joint osteoarthritis, post-traumatic arthritis, and/or rheumatoid arthritis with all of the following criteria: (Severe pain (preventing a good night's sleep) or functional disability that interferes with activities of daily living or work; & Positive radiographic findings (e.g., shoulder joint degeneration, severe joint space stenosis); & Conservative therapies (including NSAIDs, intra-articular steroid injections, and physical therapy) have been tried for at least 6 months and failed); OR Treatment of proximal humeral fracture nonunion, malunion, or avascular necrosis, as criteria necessary to support the medical necessity of total shoulder arthroplasty. In addition, ODG identifies that total shoulder arthroplasty for the treatment of osteoarthritis is recommended over hemiarthroplasty as hemiarthroplasty offered less satisfactory results. Furthermore, ODG identifies that the most common indication for hemiarthroplasty is acute fracture. Within the medical information available for review, there is documentation of a diagnosis of bilateral shoulder arthritis. In addition, there is documentation of Activity limitation for more than four months, clear clinical; and imaging evidence of a lesion that has been shown to benefit, in both the short and long-term, from surgical repair. Furthermore, there is documentation of severe pain; positive radiographic findings (shoulder joint degeneration); & Conservative therapies (medications, intra-articular steroid injections, and physical therapy) have been tried for at least 6 months and failed. However, there is no documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs. Therefore, based on guidelines and a review of the evidence, the request for 1 Total shoulder replacement: left shoulder first then right shoulder 2 months later between 10/23/2014 and 1/25/2015 is not medically necessary.

Associated Surgical Services: 1 medical clearance w/ internal Medical Associates: 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 Services: 1 day inpatient hospital stay between 10/23/2014 and 1/25/2015: 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 Services: 1 Ultra Sling between 10/23/2014 and 1/25/2015: 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 Services: 1 TENS unit between 10/23/2014 and 1/25/2015: 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 Services: 2 Weeks rental- Vascutherm unit between 10/23/2014 and 1/25/2015: 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 Services: 18 Sessions of post-op physical therapy between 10/23/2014 and 1/25/2015: 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.