

<b>Case Number:</b>	CM15-0115418		
<b>Date Assigned:</b>	06/29/2015	<b>Date of Injury:</b>	09/29/2014
<b>Decision Date:</b>	09/09/2015	<b>UR Denial Date:</b>	06/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/15/2015

### 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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 9/29/2014. She reported feeling a cracking sensation and right shoulder pain. Diagnoses have included right biceps tendon rupture, massive tear right rotator cuff with arthropathy and right shoulder pain. Treatment to date has included physical therapy and medication. Magnetic resonance imaging (MRI) of the right shoulder from 11/17/2014, showed a massive full-thickness rotator cuff tear involving essentially the entire supraspinatus and infraspinatus components of the cuff. Superior subluxation of the humeral head was noted, along with tearing of the biceps and degeneration of the superior labrum. According to the progress report dated 5/26/2015, the injured worker complained of pain and dysfunction about the shoulder. She rated her pain as 7-8/10. Inspection of the right shoulder showed moderate atrophy super and infraspinatus. There was retracted scapula secondary to significant rotator cuff disease and positive rupture with positive Popeye sign. There was tenderness to palpation of the anterior and posterior glenohumeral joints, rotator cuff/lateral bursa shelf and biceps tendon. Authorization was requested for reverse right shoulder arthroplasty with surgical assistant and related services.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Reverse shoulder arthroplasty, right 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, Shoulder.

**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.

**Decision rationale:** The ODG guidelines for shoulder arthroplasty are as follows: 1) severe pain preventing a good night's sleep or functional disability that interferes with ADLs or work; 2) positive radiographic findings (shoulder joint degeneration, or joint space stenosis); 3) trial and failure of conservative treatments to include NSAIDs, physical therapy, and intraarticular injections for at least 6 months. The injured worker has failed conservative measures for more than 6 months per documentation reviewed however; the imaging studies fail to show significant evidence of glenohumeral arthropathy. This injured worker also has trouble sleeping, and her condition is affecting her ability to perform activities of daily living (ADLs) and work. The ODG recommendations reverse shoulder arthroplasty in those who have irreparable rotator cuff injuries and arthropathy. It is noted the claimant would likely receive little to no benefit given her atrophy, according to the surgeons notes reviewed however, without evidence of arthropathy, including joint space degeneration (severe), and/or stenosis, the guidelines are not met and as a result, the request cannot be supported.

**Associated surgical service: Surgical assistant:** 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: Inpatient hospital stay x 2-3 days:** 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.

**Pre-operative labs: CBC, BMP:** 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.

**Pre-operative EKG:** 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.

**Pre-operative chest x-ray:** 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 cold therapy unit with pad:** 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 sling immobilization for right shoulder:** 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 Breg exercise kit for right shoulder:** 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 physical therapy 2 x 6 for right shoulder:** 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.