

Case Number:	CM15-0025521		
Date Assigned:	02/18/2015	Date of Injury:	01/15/2000
Decision Date:	04/01/2015	UR Denial Date:	01/28/2015
Priority:	Standard	Application Received:	02/10/2015

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: Illinois, California, Texas
 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 76-year-old male who sustained an industrial injury on 1/15/00. Past surgical history was positive for multiple left elbow surgeries, including total left elbow replacement on 11/18/11 with significant on-going symptoms and significant functional disability. There were multiple additional surgeries noted on the right wrist including fusion, bilateral total knee arthroplasties, and right total hip replacement. The 10/31/14 orthopedic consult report documented history of injury and treatment. Right shoulder pain was reported anteriorly and laterally with loss of motion on all planes. There was decreased endurance and weakness of the right shoulder, with persistent clicking and crepitus with motion. He could not perform activity above shoulder level on the right. Right shoulder exam documented range of motion as forward flexion 90, abduction 80, extension 40, external rotation 45, internal rotation 20, and adduction 25 degrees. Right shoulder strength in forward flexion, abduction and external rotation was 4-/5, and 5/5 in internal rotation. There was persistent atrophy of the right shoulder girdle. Right shoulder radiographic studies reportedly showed massive rotator cuff tear, possible biceps tendon tear, possible superior labral tear, cuff tear arthropathy, and moderate acromioclavicular degenerative joint disease. Prior recommendations for reverse right total shoulder arthroplasty were noted. The 12/10/14 treating physician report cited increasing right shoulder pain and difficulty during the day. Physical exam documented mild atrophy and crepitus, abduction strength 4-/5, and internal rotation strength 5/5. Right shoulder range of motion included forward flexion 85 and external rotation 15 degrees, with internal rotation to L5. The diagnoses included right shoulder massive rotator cuff tear and degenerative arthritis, and

status post left reverse total shoulder arthroplasty. The patient had failed conservative treatment. On 1/28/15, utilization review non-certified the request for reverse right shoulder arthroplasty with assistant, and associated surgical service: 2 day hospital stay, post-operative Norco 10/325mg #60, and post-operative physical therapy x 12 sessions. The MTUS, ACOEM and ODG Guidelines were cited. The rationale for non-certification noted that there was a diagnosis of right shoulder massive rotator cuff tear but no imaging or operative reports were provided, and there were no details regarding conservative treatment to the right shoulder. Additionally, the patient had significant issues with the left elbow, and the patient would have a significant bilateral upper extremity disability in the post-operative period. On 2/10/15, the injured worker submitted an application for IMR.

IMR ISSUES, DECISIONS AND RATIONALES

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

Reverse right shoulder arthroplasty with assistant: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-212. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Indications for Surgery - Reverse Shoulder Arthroplasty and on the Non-MTUS Milliman Care 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: Arthroplasty; Reverse shoulder arthroplasty and Other Medical Treatment Guidelines Centers for Medicare and Medicaid services Physician Fee Schedule Assistant Surgeons <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx>.

Decision rationale: The California MTUS does not provide recommendations for this procedure. The Official Disability Guidelines recommend arthroplasty for selected patients. Surgical indications include glenohumeral or acromioclavicular joint osteoarthritis with severe pain preventing a good night's sleep or functional disability that interferes with activities of daily living or work, positive radiographic findings of shoulder joint degeneration, and failure of at least 6 months of conservative treatment. For reverse arthroplasty, the patient must meet all the following criteria: limited functional demands, intractable pain that has not responded to conservative therapy (including anti-inflammatory medications, intra-articular steroid injections and physical therapy for at least 6 months and failed), adequate range of motion to obtain functional benefit from the prosthesis, adequate deltoid function, residual bone permits firm fixation of implant, no evidence of infection, and no severe neurologic deficiency. The Centers for Medicare & Medicaid Services (CMS) has revised the list of surgical procedures which are eligible for assistant-at-surgery. Guidelines support an assistant surgeon for a reverse total shoulder arthroplasty. Guideline criteria have not been met. There is significant right shoulder pain and functional disability noted that interfere with sleep and activities of daily living. There were no radiographic or imaging reports in the available records documenting significant glenohumeral joint degenerative or assessments of residual bone. There is poor shoulder range of motion and shoulder muscle atrophy. Detailed evidence of up to 6 months of a recent, reasonable

and/or comprehensive non-operative treatment protocol trial, including physical therapy and injections, and failure has not been submitted. Therefore, this request is not medically necessary.

Associated surgical service: 2 day hospital stay: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-212. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Indications for Surgery - Reverse Shoulder Arthroplasty and on the Non-MTUS Milliman Care 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: Hospital length of stay (LOS).

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary. As the surgical request is not supported, this request is not medically necessary.

Associated surgical service: 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), Shoulder Chapter, Immobilization.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205, 213.

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

Post-operative Norco 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 3 Initial Approaches to Treatment Page(s): 47-48, Chronic Pain Treatment Guidelines Page(s): 79-81. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain 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.

Post-operative physical therapy x 12 sessions: Upheld

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

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: 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), Shoulder, continuous-flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Continuous flow cryotherapy.

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