

Case Number:	CM15-0031559		
Date Assigned:	03/26/2015	Date of Injury:	12/01/2007
Decision Date:	05/14/2015	UR Denial Date:	02/04/2015
Priority:	Standard	Application Received:	02/19/2015

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

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 70-year-old male who reported an injury on 12/01/2007. The mechanism of injury was not provided. However, it was noted that he had received multiple surgical interventions to his right knee for injuries sustained on 12/01/2007 and had subsequently injured his left shoulder using crutches postoperatively. He is diagnosed with rotator cuff tear, left shoulder chronic impingement, and left shoulder pain. An MRI of the left shoulder was performed on 09/11/2014. The MRI revealed a high-grade tear of the rotator cuff with retraction and atrophy, as well as a labral tear/degeneration and glenohumeral and acromioclavicular arthropathy. On 01/21/2015, the injured worker was seen for follow-up and review of his shoulder MRI. It was noted that his left shoulder pain was chronic and was limiting his function. Physical examination revealed weakness to the left shoulder and significantly decreased range of motion. It was noted that he had difficulty elevating the shoulder above 110 degrees, but was able to abduct to 90 degrees if he contorts his left scapula. He was also noted to have significant weakness in both directions with flexion to 3/5 and abduction to 3+/5. His external rotation was noted to be quite weak at 3-/5 and he was only able to externally rotate to 15 degrees actively and 30 degrees passively. He was also shown to have subacromial crepitation and pain with motion. X-rays of the left shoulder demonstrated a type 2 acromion, a reasonably well preserved subacromial space, no significant cephalad migration of the humeral head, and enthesopathy changes at the greater tuberosity. The treatment plan included a reverse shoulder arthroplasty to treat and relieve the injured worker's symptoms from his massive left rotator cuff tear. Rationale for the requested associated procedures was not provided. The documentation also showed that

the injured worker had extensive conservative treatment and surgical intervention for his right knee condition. However, documentation regarding previous treatment for the left shoulder was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Reverse Left Shoulder Arthroplasty: 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), Treatment Index, 13th Edition (web), 2015, Shoulder - Reverse Shoulder Arthroplasty.

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.

Decision rationale: According to the Official Disability Guidelines, reverse shoulder arthroplasty may be recommended for a nonfunctioning irreparable rotator cuff and glenohumeral arthropathy when there are limited functional demands and intractable pain that has not responded to conservative therapy to include NSAIDs, intra-articular steroid injections, and physical therapy for at least 6 months. The clinical information submitted for review indicated that the injured worker reported left shoulder pain following use of crutches after a previous right knee surgery. Previous documentation is largely focused on treatment of his right knee condition with mention of left shoulder pain. However, details regarding previous treatment of the left shoulder were not provided. He was shown to have a massive rotator cuff tear on MRI and significant findings on physical examination to warrant the requested surgery. However, in the absence of documentation showing that he had tried and failed at least 6 months of NSAIDs, steroid injections, and physical therapy for the left shoulder, the request is not supported. As such, the request is not medically necessary.

Length of Stay (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.

Assistant Surgeon: 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.

Skilled Nursing Facility (14-day stay): 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 (12-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.

Home Health Evaluation and Safety Check: 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 Lab: CBC, Metabolic Panel: 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.

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.

Chest X-Ray: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision. CharFormat

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.

UA: 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 Lab: PT/PTT Test and Mersa Swab: 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.

Home Health Post Physical Therapy (12-sessions): 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.

Ice Machine: 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.