

Case Number:	CM14-0011680		
Date Assigned:	02/21/2014	Date of Injury:	07/18/2000
Decision Date:	06/25/2014	UR Denial Date:	01/16/2014
Priority:	Standard	Application Received:	01/29/2014

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 California. 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:

This 57-year-old male lead construction technician sustained a cumulative trauma injury relative to neck and right shoulder, date of injury 7/18/2000. He is status post multiple cervical spine surgeries. Most recently, he underwent anterior cervical discectomy and fusion at C2 through C5 with revision of prior fusion C5-T1 on 6/5/13. He underwent right shoulder arthroscopic derangement surgery 5 or 6 years ago. Past medical history was positive for hepatomegaly, abnormal electrocardiogram (EKG) findings of bradycardia, and gastroesophageal reflux disease. The 1/21/13 right shoulder magnetic resonance imaging (MRI) impression was glenohumeral joint arthritic changes with severe thinning of the articular cartilage, tear of the superior labrum and tendinosis of the long head of the biceps tendon, mild supraspinatus tendinosis with no rotator cuff tear, and tear of the posterior labrum. The 9/25/13 agreed medical evaluation (AME) supplemental report documented that the patient had increasing shoulder pain, "brutally painful" at night, and was almost unable to use the shoulder whatsoever. Past medical history of complex regional pain syndrome type I affecting his left upper extremity was noted. The evaluation for right total shoulder replacement had been recommended on 8/7/12 but delayed to address cervical spine issues first. Referral to an orthopedic specialist to assess candidacy for shoulder replacement was again recommended. The 12/10/13 orthopedic consult report cited subjective complaint of right shoulder pain that comes and goes, worse when sleeping on the right side. He had pain rotating the shoulder and grinding. Right shoulder exam findings documented moderate anterior and mild lateral pain, and 0 anterior, posterior and inferior translation. There was 4/5 supraspinatus and infraspinatus strength, positive impingement test, and moderate atrophy in the supraspinatus fossa. X-rays revealed severe osteoarthritis with concentric wear. A right total arthroplasty was recommended. Records indicated the patient was a current smoker and noted

considerable alcohol use. The 1/16/14 utilization review denied the request for total right shoulder arthroplasty based on an absence of documented conservative treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

TOTAL SHOULDER ARTHROPLASTY RIGHT SIDE: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Indications for Surgery (<http://www.odg-twc.com/odgtwc/shoulder.htm>)

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 California MTUS does not provide recommendations for a right shoulder arthroplasty. 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. Guideline criteria have been met. This patient presents with radiographic and imaging findings of severe glenohumeral osteoarthritis, severe pain limiting sleep, and significant functional disability. Reasonable conservative operative and non-operative treatment has been attempted and failed. Therefore, this request for right shoulder arthroplasty is medically necessary.

MEDICAL CLEARANCE: Overturned

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 Institute for Clinical Systems Improvement (ICSI). Preoperative evaluation

Decision rationale: The California MTUS guidelines do not provide recommendations for medical clearance. Evidence based medical guidelines indicate that a basic pre-operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Guideline criteria have been met. This 57-year-old male is a current smoker with positive past medical history for hepatomegaly and abnormal electrocardiogram (EKG) and undergoing a major joint surgery. Middle-aged males who smoke have increased cardiovascular risk factors. Therefore, this request for medical clearance is medically necessary.

POST-OPERATIVE ULTRA SLING: Overturned

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, Post-operative pillow abduction sling

Decision rationale: The California MTUS do not provide recommendations for post-operative Ultra sling in chronic injuries. The Official Disability Guidelines support the use of post-operative bracing as an option following open shoulder surgeries. Therefore, this request for post-operative Ultra sling is medically necessary.

POST-OPERATIVE TENS UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, electrical stimulation (<http://www.odg-twc.com/odgtwc/shoulder.htm>)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Post-Operative Pain (transcutaneous electrical nerve stimulation), Page(s): 116-117.

Decision rationale: Under consideration is a request for a post-operative TENS unit. The California MTUS guidelines indicate that TENS is a treatment option for acute post-operative pain in the first 39 days after surgery, however it has not been shown to be effective for orthopedic surgical procedures. Guideline criteria have not been met. There is no indication that analgesic medications will be insufficient to manage post-operative pain complaints. In the absence of guideline support, this request for a post-operative TENS unit is not medically necessary.

POST-OPERATIVE VASCUTHERM UNIT X 2 WEEKS: 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), Low Back Chapter, Cold Heat Packs (http://www.odg-twc.com/odgtwc/low_back.htm#Coldheatpacks)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Cold Compression Therapy

Decision rationale: The California MTUS guidelines are silent regarding cold compression units. The Official Disability Guidelines do not recommend combined cold compression therapy in the shoulder. Given the absence of guideline support for this device, the request for a post-operative VascuTherm unit for 2 weeks is not medically necessary.