

Case Number:	CM14-0081406		
Date Assigned:	07/18/2014	Date of Injury:	09/27/2010
Decision Date:	08/25/2014	UR Denial Date:	05/05/2014
Priority:	Standard	Application Received:	06/02/2014

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 Orthopaedic 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 43-year-old male sustained an industrial injury on 9/27/10. Injury occurred while pulling his body up steps with his left arm. He felt a pop in the shoulder with immediate onset of pain. The 3/26/13 left shoulder MRI showed an abnormality in the marrow in addition to early degenerative arthritis. The patient was diagnosed with lymphoma. He underwent chemotherapy and stem cell transplantation and did well, with continued and on-going monitoring. The 2/25/14 treating physician report indicated the patient had probable left shoulder osteoarthritis. The treatment plan recommended evaluation by Infectious Disease and consideration of joint aspiration for changes about the humerus and glenoid in cultures, sensitivities, and cell count. The 4/9/14 joint aspiration procedure report indicated findings of trace left glenohumeral joint fluid. There were marked osteophytes of the left glenohumeral joint indicating osteoarthritis. The 4/21/14 treating physician report documented a left glenohumeral joint fluid aspiration consistent with osteoarthritis. Radiographs reportedly showed fairly severe degenerative shoulder changes. The treatment plan recommended either a left total shoulder replacement or hemiarthroplasty. The 5/5/14 utilization review denied the request for left shoulder surgery based on lack of documented conservative treatment and documented findings from joint aspiration.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left total shoulder replacement: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (www.odgtwc.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 (shoulder).

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. Guideline criteria have not been met. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried for at least 6 months and failed. There is no pain or functional assessment documented. Records suggest fairly severe degenerative changes but no specific radiology report is available. Therefore, this request for left total shoulder replacement is not medically necessary.

Surgery with 3 day inpatient stay: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (www.odgtwc.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, Hospital length of stay (LOS).

Decision rationale: As the request for left shoulder surgery is not medically necessary, the associated request for surgery with a 3-day inpatient stay is also not medically necessary.

hemiarthroplasty: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (www.odgtwc.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 (shoulder).

Decision rationale: The California MTUS does not provide recommendations for this procedure. The Official Disability Guidelines generally recommend arthroplasty over hemiarthroplasty. 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 not been met. There is no detailed documentation that recent comprehensive pharmacologic and non-pharmacologic conservative treatment had been tried for at least 6 months and failed. There is no pain or functional assessment documented. Records suggest fairly severe degenerative changes but no specific radiology report is available. Therefore, this request for hemiarthroplasty is not medically necessary.