

Case Number:	CM15-0101671		
Date Assigned:	06/04/2015	Date of Injury:	06/19/2007
Decision Date:	07/07/2015	UR Denial Date:	04/25/2015
Priority:	Standard	Application Received:	05/27/2015

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:

This injured worker is a 58-year-old male who sustained an industrial injury on 6/19/07. The mechanism of injury was not documented. Past surgical history was positive for left total shoulder arthroplasty. The 10/23/08 right shoulder MRI impression documented at least moderate osteoarthritis changes in the glenohumeral joint, and moderate osteoarthritic changes in the acromioclavicular joint including some spurring along the inferior joint margin which could cause impingement. There was no rotator cuff injury seen. Recent treatment included injections, ice, rest and medications. The progress reports from 2011 through 2014-documented progressive right shoulder pain with clicking and grating since 2007. Physical exam findings documented limited range of motion and weakness. The diagnosis was end-stage right shoulder osteoarthritis. He had failed conservative treatment including therapy. Right shoulder injections were providing short-term relief. Authorization for right total shoulder arthroplasty was repeatedly requested. The 2/17/15 treating physician report cited right shoulder joint pain, swelling, and stiffness with a documented history of osteoarthritis. His left shoulder had been replaced and was doing well. Objective findings documented decreased range of motion with forward elevation to 80 degrees and abduction painful at 95 degrees. External rotation was 30 degrees and internal rotation 20 degrees. He had pain and grinding with range of motion. Rotator cuff strength was good. Radiographs were reviewed from prior and confirm osteoarthritic change. The diagnosis was shoulder synovitis in the face of osteoarthritis. He had injections in the past at 3-4 month intervals with good success. A corticosteroid injection was performed. On 4/17/15, a request for authorization was submitted for right shoulder arthroplasty with preoperative medical clearance, postoperative physical therapy and associated surgical services.

The 4/25/15 utilization review non-certified the right total shoulder arthroplasty and associated surgical requests as there was no documentation of guideline-recommended physical therapy or recent clinical imaging. The 5/19/15 treating physician report indicated that the injured worker had osteoarthritis of the right shoulder and had failed conservative treatment. He was receiving corticosteroid injection treatment for symptoms control with diminishing results.

IMR ISSUES, DECISIONS AND RATIONALES

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

Total shoulder arthroplasty (right): Overturned

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 (Acute & Chronic): Arthroplasty (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 (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 been met. This injured worker presents with progressive right shoulder pain and functional impairment that has precluded work duties and interferes with activities of daily living. Clinical exam findings have been consistent with is positive radiographic evidence of right shoulder acromioclavicular and glenohumeral joint osteoarthritis. Evidence of weeks-month(s) of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Therefore, this request is medically necessary.

Pre-operative medical clearance: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery General Information and Ground Rules, California Official Medical Fee Schedule, pages 92-93.

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. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2010 Jun. 40 p.

Decision rationale: The California MTUS guidelines do not provide recommendations for pre-operative medical clearance. Evidence based medical guidelines indicate that a basic pre-

operative assessment is required for all patients undergoing diagnostic or therapeutic procedures. Middle-aged females have known occult increased medical/cardiac risk factors. Guideline criteria have been met based on patient age, magnitude of surgical procedure, recumbent position, fluid exchange and the risks of undergoing anesthesia. Therefore, this request is medically necessary.

Post-operative physical therapy (12 sessions): Overturned

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

Decision rationale: The California MTUS Post-Surgical Treatment Guidelines for shoulder arthroplasty suggest a general course of 24 post-operative visits over 10 weeks during the 6-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 12 visits. If it is determined additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. This request for physical therapy is consistent with initial treatment guidelines. Therefore, this request is medically necessary.

Durable medical equipment (DME) shoulder sling: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205.

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

Decision rationale: The California MTUS guidelines state that the shoulder joint can be kept at rest in a sling if indicated. Slings are recommended as an option for patients with acromioclavicular separations or severe sprains. Prolonged use of a sling only for symptom control is not recommended. Guideline criteria have been met. The use of a post-operative sling is generally indicated. Therefore, this request is medically necessary.

Durable medical equipment (DME) cold therapy 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 (Acute & Chronic): 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: The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days, including home use. The use of a cold therapy unit would be reasonable for 7 days post-operatively. However, this request is for an unknown length of use, which is not consistent with guidelines. Therefore, this request for one cold therapy unit is not medically necessary.