

<b>Case Number:</b>	CM15-0018439		
<b>Date Assigned:</b>	03/11/2015	<b>Date of Injury:</b>	09/19/2008
<b>Decision Date:</b>	04/09/2015	<b>UR Denial Date:</b>	01/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/30/2015

### 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 49-year-old male who sustained an industrial injury on 9/19/08. Injury to the neck and both shoulders occurred relative to cumulative trauma. Past surgical history was positive for left shoulder labral repair and distal clavicle resection in 2012. The 11/10/14 treating physician report cited bilateral shoulder pain. He had a corticosteroid injection to the right shoulder at the last visit with some relief. The left shoulder exam documented glenohumeral joint crepitus, forward elevation 80 degrees, external rotation 20 degrees, and internal rotation to L5. Right shoulder MRI findings were reviewed. The diagnosis was left shoulder traumatic arthritis, left shoulder posterior glenohumeral joint traumatic instability, left shoulder supraclavicular pain of unknown etiology, and right shoulder pain secondary to supraspinatus tendinosis. Neuro-surgical evaluation was pending for the cervical spine, prior to proceeding with left total shoulder arthroplasty. The 12/16/14 treating physician report cited grade 6/10 left shoulder pain with medications, and 7-8/10 without. Difficulty was reported in grooming, activities of daily living, and folding laundry. He was using a TENS unit 2 to 3 times per week. Medications included gabapentin, Norco, Oxycontin, and Lidoderm patches. Physical exam documented right shoulder MRI findings. Left shoulder exam findings documented forward flexion 145 with a painful arc, abduction 125 degrees using compensatory cervical spine accessory muscles, external rotation 70 degrees, and internal rotation to the left gluteus. There was 2+ crepitus, 3/5 rotator cuff strength, and tenderness to palpation over the deltoid, biceps, and triceps. The treatment plan recommended follow-up for left total shoulder arthroplasty. On 1/21/15, utilization review non-certified a left shoulder total arthroplasty, pre-operative labs, per-operative

medical clearance, and 2 days inpatient stay, noting the request for the left shoulder arthroplasty was not supported based on the medical records submitted, and as the surgery was not supported, the inpatient stay and pre-operative screening was also not supported. The Official Disability Guidelines (ODG) were cited. On 1/30/15, 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:

**2 days inpatient stay:** Upheld

**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: Hospital length of stay (LOS).

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

**Pre-operative labs:** Upheld

**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 Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology* 2012 Mar; 116(3):522-38.

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

**Pre-operative medical clearance:** Upheld

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

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

**Left shoulder total arthroplasty: Upheld**

**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: Arthroplasty.

**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. The patient presents with persistent function-limiting bilateral shoulder pain. There is no imaging evidence of left glenohumeral or acromioclavicular joint osteoarthritis documented in the available records. Detailed evidence of up to 6 months of a recent, reasonable and/or comprehensive non-operative treatment protocol trial for the left shoulder and failure has not been submitted. Therefore, this request is not medically necessary.