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Date notice sent to all parties: 05/06/15

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left total shoulder arthroplasty, cold unit, and ultra sling

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified in Orthopedic Surgery
Diplomate of the American Board of Orthopedic Surgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

Left total shoulder arthroplasty, cold unit, and ultra sling - Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

examined the patient on 06/30/08 and he was injured on xx/xx/xx when he was chasing xx and lost his footing, hitting his left shoulder, left elbow, and left knee. He had AC joint and minimal rotator cuff tenderness. Forward elevation was 150 degrees and external rotation was 40 degrees. X-rays revealed mild spurring involving the AC joint, as well as mild sclerosis involving the greater tuberosity of the humerus and cystic changes involving the humeral head. The acromion was

type III. The diagnoses were a left shoulder strain and an AC joint contusion where he already had osteoarthritis. He also had left elbow and knee abrasions that had healed and it was noted he was overweight. Mobic and Norco were refilled. On 09/22/08, performed a left shoulder AC joint steroid injection. The patient described almost complete pain relief from the injection when he returned to on 10/06/08. He had full active movement without complaints and he had no tenderness. noted his left shoulder sprain and AC joint contusion had basically resolved following the injection. On 11/10/08, performed another steroid injection into the left shoulder. On 04/13/09, the patient informed the steroid injection localized his pain to the AC joint. He was tender over the AC joint and to a lesser extent at the rotator cuff. Forward elevation was 150 degrees and external rotation was 40 degrees. The patient did not wish to pursue additional evaluation or surgical treatment at that time. He was returned to full work duty. The patient then followed-up with on 08/10/09 with intermittent pain to the AC joint. He had no radicular pain or neurological symptoms. Regular work duty was continued. On 08/29/11, noted he had not seen the patient since 08/10/09. He continued with intermittent aching and electrical pain involving the left shoulder, as well as a grinding sensation that he localized to the left AC joint that had been worse recently. He described neck stiffness, but no radicular pain or neurological symptoms. Forward elevation was 120 degrees and elevation was 30 degrees. He was 230 pounds. There was no motor weakness or sensory loss. He was tender at the AC joint. A left shoulder AC joint steroid injection was then performed with excellent pain relief. On 12/08/11, the patient informed he had two months of complete pain relief following the steroid injection. It was felt his work injury aggravated his AC joint osteoarthritis. Another steroid injection was performed at that time. On 03/15/12, the patient again received two months of complete pain relief from the steroid injection. He complained of neck stiffness without radicular pain or neurological symptoms. A preoperative evaluation was recommended, as noted repeated steroid injections were not appropriate for the long term. A left shoulder arthrogram was recommended and the left shoulder AC joint was again injected. A left shoulder MR arthrogram dated 11/01/12 revealed a full thickness tear of the rotator cuff with retraction of the tendon by 15 mm. without atrophy. There was contrast extravasated into the subacromial and subdeltoid bursae. There were hypertrophic productive changes of the AC joint with downward sloping of the acromion and grade I impingement of the supraspinatus. wrote a letter on 12/07/12 requesting left shoulder arthroscopy with subacromial decompression, extensive debridement, and rotator cuff repair. On 05/10/13, the patient followed-up with. A left shoulder steroid injection was performed at that time. On 11/08/13, the patient had constant left shoulder pain, clicking, and grinding with radiation to the left hand. He denied neurological symptoms other than left shoulder weakness he related to pain. Forward elevation was 90 degrees and external rotation was 30 degrees. He had no crepitus or laxity. Strength was reduced in the left shoulder due to pain, but there were no sensory losses. noted the patient had a left shoulder sprain/strain and contusion with AC joint osteoarthritis that was aggravated by the injury, as well as a rotator cuff that represented an acute tear, acute on chronic tear, or chronic tear

that was also aggravated by the injury. Surgery would be pursued once his claim was settled and another steroid injection was performed at that time.

performed left shoulder arthroscopy with subacromial decompression, extensive debridement, synovectomy, excision of distal end of clavicle, tenodesis of the long head of the biceps tendon, and mini open rotator cuff repair on 03/19/14. On 03/21/14, he described numbness and tingling in the left upper extremity felt was likely related to the nerve block. Passive exercises were recommended. On 06/25/14, noted the patient had continued left shoulder pain and numbness, tingling, and weakness. He had received 8 sessions of therapy with four left. IT was felt he had adhesive capsulitis. A CPM unit was recommended. performed left shoulder MUA and steroid injection on 07/09/14. The patient was unchanged when he followed-up with on 07/22/14. External rotation was 0 degrees and forward elevation was 30 degrees actively and 70 passively. He had slight swelling involving the distal extremity. He had generalized decreased sensation to light touch in the left upper extremity. wondered about the possibility of CRPS and he was referred to pain management. Neurontin was prescribed. An EMG/NCV study dated 08/02/14 revealed an acute left C7 radiculopathy with active denervation. On 09/11/14, noted he did not believe the neck was part of the work injury, although it might be complicating his left shoulder. A cervical MRI was recommended, which was performed on 09/26/14. It revealed narrowing of the left lateral recess at C5-C6 by a 0.3 cm. posterior disc protrusion. This was centered to the left lateral recess, but it also caused borderline central spinal canal stenosis. The patient returned to on 09/30/14. He had left shoulder pain that radiated into the left side of his neck, as well as his left arm and forearm with numbness, tingling, weakness, and swelling. It was felt he had developed a chronic pain syndrome. A referral to a neurosurgeon was recommended. a DDE on 10/14/14. Palpation of the left shoulder was not possible due to extreme discomfort and it was difficult to note where compression on the brachial plexus or on the cervical nerve roots itself was occurring. Axial loading was positive on the left and shoulder orthopedic testing could not be done due to pain. Left shoulder range of motion could not be evaluated due to discomfort. Cervical flexion was 20 degrees, extension was 15 degrees, right rotation was 22 degrees, and left rotation was 15 degrees. The patient noted he had been recommended for surgery, including possible shoulder replacement. felt the patient was not at MMI and he felt cervical radiculitis or brachial neuritis were included in the patient's injury, as these diagnoses were normal sequelae of long term degrading shoulder conditions. It was felt he should be off of work through 03/02/15. A left shoulder MRI on 10/17/14 revealed postsurgical changes including resection of the lateral tip of the left clavicle, repair of the proximal tear of the biceps tendon and rotator cuff repair. There was no evidence of an acute tear and there was tendinosis of the subscapularis tendon. examined the patient on 11/23/14. He had limited range of motion and the patient would not allow to passive move his elbow or wrist past his active limits and he did not appreciate pronounced capsular stiffness. Sensation was subjectively decreased at C5 and C7. He noted the patient had symptoms that were not related to his shoulder and he was concerned for CRPS or RSD. explained the shoulder arthroplasty would be

better done once all of his other issues were treated. On 12/09/14, noted the patient's recent x-rays noted narrowing of the shoulder joint and he noted advised him to find a doctor that specialized in shoulder replacement. again informed the patient total shoulder arthroplasty would be best performed once his other symptoms/pain syndrome had been treated. performed a post DDE RME on 12/10/14. It was noted here he had diabetes mellitus. recommended an EMG/NCV prior to completing his report and he then provided an addendum. He noted the EMG/NCV study indicated no evidence of cervical radiculopathy, brachial plexopathy, or significant upper extremity nerve involvement. Incidental carpal tunnel syndrome on the left was noted and noted with 100% medical certainty this was not related to the original injury. He also noted the DDE's statement regarding cervical radiculitis and brachial plexopathy was incorrect and erroneous. felt the patient was not at MMI and noted because of the loss of the proximal biceps tendon, the depressor effect of that tendon had been lost and as such, the humeral head might now ride superiorly, producing increased impingement and increased glenohumeral arthritic changes. He did felt the extent of injury was to the right shoulder/rotator cuff only. An EMG/NCV study dated 01/05/15 revealed mild left median mononeuropathy, performed a cervical ESI on 01/13/15. neurosurgeon, examined the patient on 01/30/15. He had diffuse weakness to the left deltoid, bicep, left wrist extensor, triceps, and grip muscle groups. He was unable to lift his arm above 30 degrees. He had a decreased left brachial reflex. and noted the patient had paralysis of the left upper extremity and atrophy of the left arm. Cervical fusion at C5-C6 was recommended. On 02/03/15, the patient followed-up with. It was noted the cervical component of his injury was not to be included in his work injury. Attempted passive and active range of motion elicited maximum pain. again recommended addressing as much of the cervical pathology and other pain generators outside the shoulder prior to arthroplasty. Total shoulder arthroplasty arrangements would begin. On 02/27/15, a left shoulder total arthroplasty with cold unit and ultra sling were requested. On 03/09/15, provided a non-authorization for the requested left total shoulder arthroplasty, cold unit, and ultra sling. On 03/16/15, wrote an appeal for the left total shoulder arthroplasty, noting the patient met the indications for total shoulder replacement. It was felt he had a form of posttraumatic arthritis commonly called chondrolysis with severe pain, positive radiographic findings, and failed non-operative measures. On 03/18/15, provided another non-authorization for the requested left total shoulder arthroplasty, cold unit, and ultra sling. wrote a letter on 04/08/15. He felt based on reasonable medical probability, the majority if not all of the patient's left upper extremity symptoms and physical findings originated from his left shoulder and not his neck, which he felt was supported by his medical records. It was felt the requested left shoulder procedure was reasonable according to the Official Disability Guidelines (ODG).

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The patient is a xx-year-old obese male who was employed as a deputy constable for Fort Bend County. The work related injury occurred on xx/xx/xx when he was

chasing x, lost his footing, and hit his left shoulder, elbow, and knee. He sought medical attention on 06/30/08 and the diagnosis at that time was a left shoulder sprain/strain and x-rays at that time documented preexisting degenerative changes of the acromioclavicular joint, a type III acromion, and changes of the greater tuberosity and humeral head consistent with degenerative rotator cuff pathology. The patient's symptoms resolved after several acromioclavicular joint steroid injections. There was actually a gap between 08/10/09 and 08/29/11, where no medical treatment was sought. It appeared continued, for unclear reasons, to attribute the patient's recurrence of symptoms to the compensable injury. The patient eventually, four years after injury, underwent an MR arthrogram that reportedly showed a full thickness supraspinatus tendon tear with 15 mm retraction, but no evidence of atrophy. Again, this appeared to be attributed to the work related event for unclear reasons. then performed, on 03/19/14, a left shoulder subacromial decompression with distal clavicle resection, biceps tenodesis, and mini open rotator cuff repair. It should be noted that the patient experienced no improvement clinically and noted poor pain tolerance, which resulted in the patient's development of adhesive capsulitis. An MUA and steroid injection were then performed on 07/09/14. The patient again showed worsening of his condition and no functional or clinical improvement. The patient's diagnoses have been unclear with cervical radiculopathy, chronic regional pain syndrome, and even carpal tunnel syndrome reported in the medical records. A second set of electrodiagnostic studies reported as only significant for median nerve neuropathy, despite the patient complaint of global numbness and complete lack of upper extremity function. Repeat MRI scan documented no evidence of rotator cuff tear. Chondrolysis has been suggested possibly, posttraumatic. There is mention of diabetes mellitus, but its impact on this patient's symptoms has not been addressed. subsequently recommended a total shoulder arthroplasty.

This patient has already undergone a surgical procedure and subsequent MUA without any objective evidence of clinical improvement or change in his functional status. His diagnoses at this time are unclear, at best. Functionally, this patient is much worse now than immediately after the injury. The impact that his diabetes has had is not addressed in the materials reviewed. Although superficially, or on first glance, it would appear that he meets some of the ODG criteria for shoulder arthroplasty, the guidelines also recommend that caution be advised in Workers' Compensation patients, where outcomes tend to be worse in these patients. The patient clearly also has significant co-morbidities, which have not been addressed appropriately, including his cervical issues, and his ability to rehabilitate following the procedure appears poor, at best, based on the documentation reviewed at this time. In fact, recommended the cervical issues be addressed prior to performing shoulder surgery. The medical records clearly documented his inability to rehabilitate secondary to poor pain tolerance after the first procedure and the subsequent MUA. The rapid degradation of the glenohumeral joint has not been adequately explained or its etiology defined. The only recent explanation is the use of intrarticular pain pump, as reported in the orthopedic literature. Record review does not support the requested procedure as being medically necessary,

reasonable, related, or supported by the evidence based ODG. Therefore, the requested left total shoulder arthroplasty, cold unit, and ultra sling are not medically necessary, appropriate, or in accordance with the evidence based ODG and the previous adverse determinations should be upheld at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)