

RYCO MedReview

Notice of Independent Review Decision

DATE OF REVIEW: 11/27/07 (AMENDED 11/29/07)

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Right shoulder arthroplasty with humeral head fit cap/allograft on an outpatient basis

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

Board Certified in 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 or not medical necessity exists for each of the health care services in dispute.

Right shoulder arthroplasty with humeral head fit cap/allograft on an outpatient basis

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An emergency room report from an unknown physician (signature was illegible) dated 07/24/07

Nursing notes from an unknown nurse (no name or signature was available) dated 07/24/07

X-rays of the right shoulder interpreted by , M.D. dated 07/24/07

A discharge report from the unknown nurse dated 07/24/07

Evaluations with, M.D. dated 08/03/07 and 08/08/07

Prescriptions from Dr. dated 08/03/07, 08/08/07

X-rays of the right shoulder interpreted by, M.D. dated 08/03/07

Physical therapy with, P.T. dated 08/06/07, 08/08/07, and 08/09/07

An MRI of the right shoulder interpreted by, M.D. dated 08/08/07

Patient referral forms from Dr. dated 08/08/07 and 08/15/07

Physical therapy with, P.T. dated 08/13/07

Physical therapy with, P.T. dated 08/14/07

A physical therapy discontinuation summary from Mr. dated 08/23/07

An evaluation with, M.D. dated 09/14/07

A Workers' Compensation Patient Information Sheet dated 09/14/07

A letter of non-certification, according to ODG Guidelines, from, D.O., D.C. dated 09/24/07

A letter of non-certification, according to ODG Guidelines, from , M.D. dated 10/16/07

The Network Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY [SUMMARY]:

X-rays of the right shoulder interpreted by Dr. on xx./xx/xx revealed degenerative changes of the right glenohumeral joint. On xx/xx/xx, Dr. recommended an MRI of the right shoulder, physical therapy, and modified work duty. An MRI of the right shoulder interpreted by Dr. on 08/08/07 revealed supraspinatus tendinosis, severe glenohumeral joint osteoarthritis, chronic 360 degree labral tears, and moderate AC joint osteoarthrosis. Physical therapy was performed with Mr. on 08/06/07, 08/08/07, and 08/09/07. Physical therapy was performed with Mr. on 08/13/07. On 09/14/07, Dr. recommended right shoulder surgery, Lortab, and Phenergan. On 09/24/07, Dr. wrote a letter of non-certification for right shoulder surgery. On 10/16/07, Dr. also wrote a letter of non-certification for right shoulder surgery.

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

Based on the medical history, this patient has had a history of an injury and physical examination and testing revealed severe arthritis of the glenohumeral joint with labral tears. According to the requesting physician, this patient has had a history of non-steroidal anti-inflammatory use, physical therapy, and a Cortisone injection, which failed to provide any relief. The ODG does state that for severe glenohumeral arthritis, total shoulder arthroplasty is an option once

conservative measures have failed. However, based on the MRI, there is severe involvement of the glenohumeral joint and arthritis. I find it hard to believe that this amount of arthrosis could have occurred with a relatively recent injury as in this case where the patient was only injured in xxxx of 2007. Therefore, in this case, deviation from the ODG is necessary as it would appear that the proposed right shoulder arthroplasty with humeral head with fit cap/allograft on an outpatient basis is not being performed for the acute injury but for the arthritis and is not reasonable or necessary.

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)