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Notice of Independent Review Decision

DATE OF REVIEW: March 17, 2008

IRO CASE #:

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

This case was reviewed by an orthopedic surgeon, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left shoulder bio resurfacing glenoid with autogenous fascia lata

REVIEW OUTCOME

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

Overturned (disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Submitted medical records were reviewed in their entirety.
- Treatment guidelines were provided to the IRO.
- January 29, 2008 peer review report
- February 28, 2008 peer review report
- Undated provider list
- August 16, 2007 chart note from M.D.
- August 13, 2007 operative note from M.D.
- May 17, 2007 shoulder MRI report by M.D.
- September 4, 2007 report by M.D.
- November 6, 2007 report by M.D.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records, the patient sustained an industrial injury involving the left shoulder. A January 29, 2008 peer review report rendered a non-certification for the above-captioned procedure. The report states that the patient sustained a fracture of the greater tuberosity, partial thickness tear of the supraspinatus tendon, and a labral tear. He underwent shoulder diagnostic arthroscopy on August 13, 2007 and was found to have a full-thickness articular cartilage loss involving approximately one half of the glenoid surface. The patient now presents with left shoulder osteoarthritis and post-traumatic stiffness. Pain, strength, and stability remain unchanged. He complains that the shoulder feels weak, pops, and grinds with spasm. The report states that the request is not medically necessary as the imaging studies of the patient's left shoulder in May 2007 and his current clinical examination, along with the lack of follow-up imaging studies, do not support the currently requested procedures. Further clinical information and insight would be required to establish the medical necessity of this request according to the reviewing physician.

The case was again reviewed on February 28, 2008 and another non-certification rendered. This reviewer stated that within the medical reports made available for review, there is no documentation of consistent and overwhelming evidence-based guidelines

support or criteria to support the medical necessity of the requested procedure.

A May 17, 2007 left shoulder MRI includes an impression of evidence of nondisplaced fracture in the region of the greater tuberosity; small partial thickness articular surface tear distal supraspinatus tendon at the level of insertion on the greater tuberosity; some irregularity and abnormal signal in the anterior/inferior labrum, cannot exclude labral tear; and arthropathic changes of the acromioclavicular joint with no significant impingement seen.

An August 13, 2007 operative note states that left shoulder exam under anesthesia, arthroscopy, and arthroscopic debridement of glenohumeral joint was performed. The report states that there was found to be a partial thickness articular surface side tear of the rotator cuff which was less than 50% of the tendon structure. There was found to be an area of significant glenohumeral arthritis in the posterior aspect of the glenoid. Debridement of this was done. This was a full-thickness articular cartilage loss.

The records contain an August 16, 2007 note which states that the patient returned having minimal symptoms. The recommendation was for him to discontinue the sling and begin range of motion. The physician also proposed the above-captioned surgical procedure.

A September 4, 2007 report states that the patient's affected shoulder hurts, feels weak, pops or grinds, and is in spasm. The report states that there has been no help from surgery according to the patient. He was told that he had arthritis. The pain is interfering with his ability to sleep and he reports weakness. Examination findings included forward flexion 155, abduction 145, external rotation with the arm at side 30, internal rotation to T7, passive range of motion equaling active range of motion, negative impingement signs, normal strength, resisted elevation painful, resisted abduction painful, normal stability, and several negative orthopedic tests. Anterior-posterior radiographic findings included joint space maintained and dystrophic calcification. Axillary images revealed that the joint space is maintained and the scapular outlet view showed a type II acromion.

The most recent orthopedic report, dated November 6, 2007, states that the patient feels that the pain has not changed with time, movement is improving, strength is unchanged, and stability is unchanged. Examination findings include forward flexion 160, abduction 145, external rotation with the arm at the side 30, internal rotation to T7, passive range of motion equaling active range of motion, negative impingement signs, normal strength, painful resisted elevation and abduction, normal stability, and several negative orthopedic tests. The report states that the patient desires surgery in the form of biological resurfacing of glenoid with autogenous fascia lata and possibly resurfacing the head of the humerus if the humerus is involved.

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

The patient has previous x-rays, MRI, and surgical investigation within the last year which is sufficient for the diagnosis. Even though fascial interposition is not addressed by the major occupational evidence-based guidelines, it is an accepted procedure in the orthopedic community. Therefore, my determination is to overturn the previous decisions to non-certify the request for left shoulder bio resurfacing glenoid with autogenous fascia lata.

The IRO's decision is consistent with the following guidelines:

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)

__x__OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME

GUIDELINES/REFERENCES:

The Official Disability Guidelines and ACOEM Guidelines do not specifically address this procedure.

Sumant G. Krishnan, MD1, John R. Reineck, MD1, Robert J. Nowinski, DO2, Donnis Harrison, MD3 and Wayne Z. Burkhead, MD1 Humeral Hemiarthroplasty with Biologic Resurfacing of the Glenoid for Glenohumeral Arthritis The Journal of Bone and Joint Surgery (American). 2008;90:9-19.

BACKGROUND: Biologic glenoid resurfacing was developed in 1988 as an alternative to total shoulder arthroplasty in selected (usually younger) patients with primary, posttraumatic, or postreconstructive glenohumeral arthritis. A variety of biologic surfaces, including anterior capsule, autogenous fascia lata, and Achilles tendon allograft, have been combined with a humeral hemiarthroplasty.

METHODS: From November 1988 to November 2003, thirty-four patients (thirty-six shoulders) who were managed with biologic glenoid resurfacing and humeral head replacement either with cement (ten shoulders) or without cement (twenty-six shoulders) were followed prospectively. The study group included thirty men and four women with an average age of fifty-one years. The diagnoses included primary glenohumeral osteoarthritis (eighteen shoulders), postreconstructive arthritis (twelve), posttraumatic arthritis (five), and osteonecrosis (one). Anterior capsule was used for seven shoulders, autogenous fascia lata for eleven, and Achilles tendon allograft for eighteen. All shoulders were assessed clinically and with serial radiographs.

RESULTS: The mean American Shoulder and Elbow Surgeons score was 39 points preoperatively and 91 points at the time of the most recent follow-up. According to Neer's criteria, the result was excellent for eighteen shoulders, satisfactory for thirteen, and unsatisfactory for five. Glenoid erosion averaged 7.2 mm and appeared to stabilize at five years. There were no revisions for humeral component loosening. Complications included infection (two patients), instability (three patients), brachial plexitis (one patient), and deep-vein thrombosis (one patient). Factors that appeared to be associated with unsatisfactory results were the use of capsular tissue as the resurfacing material and infection.

CONCLUSIONS: Biologic resurfacing of the glenoid can provide pain relief similar to total shoulder arthroplasty. It allows selected younger patients to maintain an active lifestyle, including weight-lifting and manual work, without the risk of polyethylene wear. On the basis of this and previous reviews, we currently recommend Achilles tendon allograft as the preferred resurfacing material when this option is chosen.

LEVEL OF EVIDENCE: Therapeutic Level IV. See Instructions to Authors for a complete description of levels of evidence.

ORIGINAL ABSTRACT CITATION: "Humeral Hemiarthroplasty with Biologic Resurfacing of the Glenoid for Glenohumeral Arthritis. Two to Fifteen-Year Outcomes" (2007;89:727-34).

Burkhead WZ Jr, Hutton KS. Biologic resurfacing of the glenoid with hemiarthroplasty of the shoulder. J Shoulder Elbow Surg. 1995 Jul-Aug;4(4):263-70 A porous-coated humeral head replacement with biologic resurfacing of the glenoid was performed in 14 patients between 1989 and 1992. Six of the 14 patients had greater than 2 years of follow-up and form the basis of this report. The patients ranged in age from 33 to 54 years. Diagnoses were osteoarthritis in one, postreconstruction arthritis in four, and posttraumatic arthritis in one. The biologic resurfacing was done with either autogenous fascia lata or anterior shoulder capsule. All patients were relieved of pain. Average postoperative positions were elevation 138 degrees, external rotation 50 degrees, and internal rotation to the T12 spinous process. These results represent average increases of 57 degrees, 45 degrees, and six spinal segments, respectively. No donor site complications occurred. With Neer's rating scale there were five excellent results and one satisfactory result. We conclude that biologic resurfacing of the glenoid appears to improve the results of hemiarthroplasty and may well be the procedure of choice for young patients with end-stage glenohumeral arthritis.