

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/01/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Shoulder Arthroplasty with 3 Days LOS (23472)

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

M.D, Board Certified Orthopedic Surgeon

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)

The reviewer finds that medical necessity exists for Right Shoulder Arthroplasty. The reviewer finds that medical necessity does not exist for 3 Days LOS.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines

Office notes, Dr. 03/30/00, 04/14/00, 04/21/00, 04/25/00, 05/04/00, 05/19/00, 06/28/00, 07/19/00, 08/25/00, 09/29/00, 10/20/00, 02/13/01

Right shoulder/CT, 04/25/01

Office notes, Dr., 05/05/09, 11/23/09, 12/18/09

Peer review, Dr., 07/31/09

Notice of RME, 08/14/09

RME, Dr., 09/18/09

Peer review, Dr., 01/21/10

Denial Letters, 1/12/10, 1/22/10

PATIENT CLINICAL HISTORY SUMMARY

This claimant is a xxxx right hand dominant male employed as a xxxx who sustained a right shoulder injury on xx/xx/xx when he reached out with his right arm to prevent a seven-foot

fall. His medical history was significant for smoking. After failed conservative measures, the claimant underwent right shoulder arthroscopy on 04/06/00 with debridement and anterior labral repair. He attended postoperative therapy. The office visit of xx/xx/xx noted no pain complaints and good rotator cuff strength. Pain recurred and a CT on 04/25/01 noted mild glenohumeral joint degenerative arthritis ; evidence of subchondral cystic change of mild degree; as well as some sclerosis along the margin of the glenoid, likely reflective of and secondary to underlying glenohumeral joint degenerative joint disease.

MRI of the shoulder noted significant progression of arthritic changes at the glenohumeral joint particularly involving the posterior margin when compared to a previous study one year prior. The findings suggested posterior capsulolabral instability, and an old reversed Bankart deformity with associated posterior labral tear and underlying subchondral cyst and cartilaginous thinning at the posterior glenoid margin superiorly. Moderate tendinosis impingement changes involving the distal supraspinatus with possible partial articular surface tear were present but minimal compared to the previous study. Mild acromioclavicular arthritis and a type II acromion were noted. Pain and markedly limited motion progressed. An injection on 04/05/05 reportedly provided three to four months of symptom relief. Office x-rays on 05/05/09 reportedly showed severe glenohumeral joint arthritis. Recent exam findings noted positive impingement signs with bone on bone crepitation, difficulty with daily activities and sleep disturbance. Right total shoulder replacement was recommended.

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

The evidence based ODG guides recommend total shoulder arthroplasty in selected patients for whom conservative treatment has failed, imaging study findings document end-stage degenerative change, and they have reasonable evidence on examination that would support the above stated diagnosis. In this particular case the records document end-stage degenerative change on imaging and a variety of treatments that have been undertaken over the course of many years all of which would qualify as conservative care. The patient also has significant limitation on range of motion that would be consistent with the underlying degenerative changes. Of note, it has been pointed out that there are no recent imaging studies or radiographs to discuss the joint findings. That said, in 2009 there are reports of severe degenerative joint changes on x-rays and there is no indication to suggest that they would have improved. Furthermore, this gentleman has been on anti-inflammatories, has had injections, and has failed reasonable conservative care as outlined. The patient satisfies the requirements in the evidence based ODG guides for right shoulder arthroplasty. However, per Milliman guidelines, a length of stay of 2 days is recommended, and this request is for a 3-day length of stay. Based on the above, the reviewer finds that medical necessity exists for Right Shoulder Arthroplasty. The reviewer finds that medical necessity does not exist for 3 Days LOS.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 updates,
Shoulder

Arthroplasty (shoulder)

Recommended for selected patients. While less common than knee or hip arthroplasty, shoulder arthroplasty is a safe and effective procedure for patients with osteoarthritis or rheumatoid arthritis. (van de Sande, 2006) Caution is advised in worker's compensation patients since outcomes tend to be worse in these patients. (Chen, 2007) In a review of 994 shoulder arthroplasties compared with 15,414 hip arthroplasties and 34,471 knee arthroplasties performed for osteoarthritis, patients who had shoulder arthroplasties had, on average, a lower complication rate, a shorter length of stay, and fewer total charges. (Farmer, 2007) The most common indication for total shoulder arthroplasty is osteoarthritis, but for hemiarthroplasty, it is acute fracture. There was a high rate of satisfactory or excellent results after total shoulder arthroplasty for osteoarthritis, but hemiarthroplasty offered less satisfactory results, most likely related to the use of this procedure for trauma. (Adams, 2007) At a minimum of two years of follow-up, total shoulder arthroplasty provided better functional outcome than hemiarthroplasty for patients with osteoarthritis of the shoulder. (Bryant, 2005)

Milliman Care Guidelines®, Inpatient and Surgical Care, 13th Edition, Shoulder Arthroplasty , Goal LOS , ambulatory to two days

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

ACOEM-AMERICA 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)