

## Notice of Independent Review Decision

**DATE OF REVIEW:** 10/06/2011

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Left shoulder total arthroplasty CPT 23472, inpatient stay day (s) x 2

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

The TMF physician reviewer is board certified in orthopedic surgery with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

### **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.

It is determined that left shoulder total arthroplasty CPT 23472, inpatient stay day (s) x 2 is not medically necessary to treat this patient's condition.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Information for requesting a review by an IRO – 09/21/11
- Utilization review letter– 09/06/11, 09/14/11
- New patient initial evaluation by Dr. – 08/23/11
- Preauthorization request from Dr. – no date
- Posting sheet for Hospital – no date
- Report of MRI of the left shoulder – 07/18/11

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This injured worker sustained a work related injury on xx/xx/xx. The patient was initially diagnosed with a left shoulder strain and was treated by his primary care provider with anti-inflammatories. He also received treatment from a chiropractor. He underwent an MRI that showed degenerative changes to the shoulder that was moderated to severe. The patient is now diagnosed with post-traumatic arthritis of the left shoulder and there is a recommendation from the orthopedic surgery for the patient to undergo a left total shoulder arthroplasty.

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

The ODG Guidelines state that the patient must have good conservative treatment. While this patient does have evidence of degenerative arthritis of the shoulder on the left side, there is no documentation of appropriate conservative care. The NAIDS given to the patient were not identifiable and there is no indication that the patient underwent the steroid injections that were recommended. This patient needs to have a good conservative program outlined and completed in order to meet the required criteria for a total shoulder arthroplasty. At this time this program has not been outlined or completed.

**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)**