

True Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Mar/3/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left total shoulder arthroplasty with a three-day inpatient stay

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

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)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported an injury regarding her left shoulder. The clinical note dated [redacted] indicates the patient stating the toe of her shoe caught on the floor resulting in a fall injuring her left upper arm. The note mentions the patient utilizing Hydrocodone for ongoing pain relief. Upon exam, tenderness was noted at the proximal humerus with no obvious deformity. The patient was able to demonstrate good range of motion. The note mentions the patient having undergone radiographic studies which revealed a comminuted fracture of the proximal humerus with displacement of the greater tuberosity. The clinical note dated 03/26/13 indicates the patient able to demonstrate 100 degrees of left shoulder flexion and abduction. 4/5 strength was noted with external rotation. The clinical note dated 06/04/13 indicates the patient able to demonstrate 90 degrees of flexion passively and 15 degrees of external rotation. Weakness continued with external rotation. The therapy note dated 06/21/13 indicates the patient having completed a 2 month course of treatment. Treatment was focused on the left shoulder. The MRI of the left shoulder dated 09/03/13 revealed an extensive remote post-traumatic deformity related to a previous humeral head and neck impact fracture with humeral shortening. Supraspinatus tendinosis was also noted. The clinical note dated 11/07/13 indicates the patient continuing with left shoulder pain. The patient was able to demonstrate 9 degrees of passive forward flexion. Glenohumeral crepitus was further noted. The clinical note dated 02/04/14 indicates the patient continuing with the use of Mobic over the previous several months for pain relief. The clinical note dated 02/04/14 indicates the patient having undergone extensive conservative treatment.

The utilization review dated 12/06/13 resulted in a denial as no information had been submitted confirming the patient's completion of all conservative treatments.

The utilization review dated 01/03/14 resulted in a denial as a failure of conservative treatment was not documented.

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

The documentation indicates the patient having severe range of motion deficits at the left shoulder following a humeral fracture. A shoulder arthroplasty would be indicated provided the patient meets specific criteria to include completion of all conservative treatments as well as severe functional deficits noted at the affected shoulder. The patient is noted to have completed more than 2 months of conservative therapy following the humeral fracture. Additionally, the patient is noted to have severe levels of range of motion deficits throughout the shoulder. Furthermore, the patient is also noted to have previously undergone the use of pharmacological interventions addressing the left shoulder pain. Given the significant clinical findings indicating severe levels of functional deficits and taking into account the previous attempts at conservative treatments as well as imaging studies confirming the patient's arthritic findings, this request is reasonable. As such, it is the opinion of this reviewer that the request for a left shoulder total arthroplasty with a 3 day inpatient stay is recommended as medically necessary.

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)