

True Resolutions Inc.

An Independent Review Organization
500 E. 4th St., PMB 352
Austin, TX 78701
Phone: 512-501-3856
Fax: 512-351-7842
Email: trueresolutions@irosolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Sept/6/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Conversion for right shoulder arthroplasty to reverse total shoulder arthroplasty with three day inpatient stay

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

Board Certified 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 medical necessity exists for each health care service in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male with a long history of right shoulder pain. The operative note dated 10/18/04 indicated the patient undergoing right shoulder arthroscopy including foreign body removal, partial synovectomy, chondroplasty, and cheilectomy. The operative note dated 11/25/08 indicated the patient undergoing right shoulder hemiarthroplasty and bicep tenodesis. A clinical note strength at operative note dated 03/26/09 indicated the patient undergoing manipulation under anesthesia at the right shoulder. A clinical note dated 06/09/10 indicated the patient continuing with right shoulder pain. The patient reported occasional bruising over the anterior aspect of the shoulder. The patient complained of swelling at the shoulder. The patient demonstrated 90 degrees of flexion and 75 degrees of abduction actively. Atrophy was identified throughout the right shoulder particularly at the posterior region. The initial clinical note dated 11/08/13 indicated the patient undergoing total of six surgeries at the right shoulder. The patient stated the ongoing right shoulder pain was interfering with his sleep hygiene. Pain was exacerbated with lifting the arm overhead and with strenuous activities. Upon exam, tenderness to palpation was identified over the lateral right shoulder specifically over the deltoid. A clinical note dated 04/09/14 indicated the patient complaining of stabbing, grinding, and sharp sensation at the right shoulder. The patient underwent physical therapy, over the counter medications, and non-steroidals activity modifications. Pain worsened with lifting arm overhead. The patient continued with home exercise program. Upon exam the patient demonstrated 70 degrees of flexion with 50 degrees of abduction. A clinical note dated 06/12/14 indicated the patient continuing with severe pain at the right shoulder. A clinical note dated 07/11/14 indicated the patient

showing significantly diminished quality of life as a result of ongoing right shoulder complaints. The patient was recommended for a reverse shoulder replacement. The utilization review dated 06/27/14 resulted in denial as no imaging studies had been submitted confirming pathology. No information was submitted regarding completion of physical therapy. The utilization review dated 07/16/14 resulted in denial for right shoulder conversion as no imaging studies had been submitted.

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

The patient complained of ongoing right shoulder pain despite number of surgical interventions. Reverse total shoulder arthroplasty is indicated provided that the patient meets specific criteria, including completion of all conservative treatment and imaging studies confirming significant pathology. The patient submitted copies of the x-rays. However, no x-ray results were submitted confirming significant pathology. Additionally, it is unclear whether the patient completed any recent conservative treatment addressing right shoulder complaints. Without imaging studies confirming significant pathology it is unclear if the patient has any rotator cuff or glenohumeral joint arthropathy or has failed the previous arthroplasty. Additionally, given that no information was submitted regarding recent completion of any conservative treatment the patient would respond appropriately to the proposed treatment. Given this, the request is not indicated as medically necessary. As such, it is the opinion of this reviewer that the request for conversion from right shoulder arthroplasty to reverse total shoulder arthroplasty with a three day inpatient stay is not recommended as medically necessary.

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

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES