Pure Resolutions LLC

Notice of Independent Review Decision

Case Number: XX Date of Notice: 4/5/2018 12:22:46 PM CST

Pure Resolutions LLC

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IRO REVIEWER REPORT
Date: 4/5/2018 12:22:46 PM CST

IRO CASE #: XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Left Reverse Total Shoulder Replacement and LOS 1-2 days

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

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

☒ Overturned	Disagree
☐ Partially Overtuned	Agree in part/Disagree in part
☐ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]: This case involves a now XX who injured his left shoulder while trying to XX. Past treatment included physical therapy. According to the MRI of the left shoulder on XXXX, the patient had recurrent full-thickness tears of the supraspinatus and infraspinatus tendons. The tear involved the full width of the interface tendon and most of all the intranasal tendon although some of the posterior fibers of the infraspinatus tendon remains intact. The tendon was retracted 4.3 cm to a level above the glenohumeral joint line. The long head of the biceps tendon was not visualized consistent with a complete tear and retraction. Osteoarthrosis was seen in the acromial clavicular and glenohumeral joints. Blunting of the superior glenoid labrum was stable which may have been from a chronic tear or degenerative change. In the clinical note dated XXXX, it was reported that the patient briefly underwent an arthroscopic left shoulder subacromial decompression/acromioplasty, glenohumeral debridement, and rotator cuff repair on XXXX. The patient had no improvement. Upon physical examination, it was noted that there was tenderness present to the anterior portion of the shoulder as well as to the subacromial region. Muscle strength was diminished with external rotation, internal rotation, and to the supraspinatus. There was also pain with manual resistance. Empty can test, Hawkins test, and speeds test were positive. The treatment plan included for the patient to undergo a left reverse total shoulder replacement.

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

According to Official Disability Guidelines, Shoulder (Acute & Chronic), a reverse shoulder arthroplasty is indicated when the patient has a non- functioning irreparable rotator cuff and has limited functional demands, intractable pain that has not responded to conservative therapy for at least 6 months, adequate deltoid function, no evidence of injection, and a

body mass index that is less than 40. There is documentation regarding the patient having a non-functioning irreparable rotator cuff upon diagnostic imaging. There is documentation regarding the patient undergoing some physical therapy. There is no documentation regarding infection. The patient also has a BMI less than 40. The patient has failed conservative care involving less invasive surgical procedures, medications, and physical rehabilitation. The patient has failed conservative care, has a non-repairable rotator cuff per diagnostic imaging, has a BMI less than 40, continues to have elevated levels of pain as well as loss of activities of daily living, and positive tests. It is reasonable and recommended that the patient undergo the surgical request at this time. Therefore, the requested Left Reverse Total Shoulder Replacement is medically necessary. Official Disability Guidelines, Shoulder (Acute & Chronic), also states that the recommended length of stay following a reverse shoulder replacement is 2 days with no complications.

The request is within the recommended guideline criteria. The request is medically necessary.

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

☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, Shoulder (Acute & Chronic), Reverse shoulder arthroplasty (RSA) and Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, Shoulder (Acute & Chronic), Hospital length of stay (LOS)