Core 400 LLC

An Independent Review Organization
2407 S. Congress Avenue, Suite E #308
Austin, TX 78704
Phone: (512) 772-2865
Fax: (512) 551-0630
Email: manager@core400.com

Review Outcome

Description of the service or services in dispute:

Right reverse total shoulder arthroplasty, postop Shoulder immobilizer

23473 - Under Repair, Revision, and/or Reconstruction Procedures on the Shoulder

L3960 - Shoulder elbow wrist hand orthosis, abduction positioning, airplane design, prefabricated, includes fitting and adjustment

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified Orthopedic Surgery

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☐ Overturned (Disagree)
- ☑ Upheld (Agree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XX is a XX who was diagnosed with post-traumatic osteoarthritis of the right shoulder (M19.111). The associated diagnosis included bicipital tendinitis of the right shoulder, acute pain of the right shoulder, impingement syndrome of the right shoulder, and sprain of right rotator cuff capsule, subsequent encounter. XX was injured on XX, when helping XX co-worker to XX XX X XX that weighed over XX XX, and the co-worker dropped XX side, causing XX to XX XX XX. XX felt a pop and kind of a pull sensation in the right shoulder.

On XX, XX was seen by XX MD for follow-up of severe pain in the right shoulder and arm. XX had right shoulder pain for two years. The pain was aching and throbbing in nature, aggravated by lifting and relieved by rest. On examination, XX blood pressure was 142/87 and BMI was 37.30. The right shoulder / upper arm examination showed a limited range of motion secondary to pain with flexion of 75 and external rotation 20. There was mild weakness of the supraspinatus on abduction and external rotation. There was pain with palpation over the greater tuberosity and subacromial bursa. Supraspinatus, Neer, and Hawkins tests were positive.

An MRI of the right shoulder dated XX showed right supraspinatus and infraspinatus tendons with high-grade, partial-thickness, partial-width tear from critical zone, extending to the insertion site but without full-thickness tear. A superior labrum anterior and posterior (SLAP) tear was noted. Tear of the posterior labrum extended from superior to inferior aspect. There was synovial thickening in the inferior glenohumeral joint with marked cartilage thinning. There were marked degenerative changes in the right glenohumeral joint with marked cartilage thinning.

The treatment to date included medications (nonsteroidal anti-inflammatory drugs), corticosteroid injections, physical therapy which provided minimal relief and surgical intervention to include extensive arthroscopic debridement, revision acromioplasty, and manipulation under anesthesia and prior arthroscopic intervention to include rotator cuff repair, labral repair, acromioplasty, and debridement on XX on XX. A previous steroid injection in XX, partially (30%) decreased shoulder pain for a short period of time.

Per a utilization review decision letter dated XX the request for right reverse total shoulder arthroplasty and postoperative shoulder immobilizer was denied by XX, MD (XX, XX). It was noted that peer-to-peer was attempted but not established. Rationale: Official Disability Guidelines supported the use of reverse shoulder arthroplasty as an option for nonfunctioning irreparable rotator cuff with

glenohumeral arthritis. Surgical intervention was supported in individuals with limited function demands, intractable pain that had not responded to conservative treatment including NSAIDs, corticosteroid injections, and physical therapy, retained adequate deltoid function, the adequate passive range of motion to obtain functional benefit from the prosthetic, no evidence of infection or neurologic deficient, adequate residual bone, and a BMI less than 40. Based on the clinical documentation provided, the requested shoulder arthroplasty was considered not medically necessary. Specifically, there was no indication that the rotator cuff was repairable, that there was advanced glenohumeral degenerative change, or that XX. XX had low functional demands. Based on the clinical documentation provided and the Official Disability Guidelines recommendations, the requested reverse shoulder arthroplasty was considered not medically necessary.

Per an appeal letter dated "XX," XX appealed the XX decision to deny coverage for right reverse total shoulder arthroplasty (23473) and postoperative shoulder immobilizer (L3960) XX documented that XX had an XX arthrogram of the right shoulder, which showed a partial thickness rotator cuff as well as post-traumatic arthritis due to XX having two prior shoulder surgeries in the past. XX believed that XX would significantly benefit from right reverse total shoulder arthroplasty with a postoperative L3690 shoulder brace to immobilize the shoulder after surgery.

A utilization review decision letter dated XX, documented that a peer-to-peer discussion was unsuccessful despite calls to the doctor's office. The prior denial was upheld by XX, MD. The reason for the determination was, XX did not meet the criteria for proceeding with the surgery. The treating physician did not confirm whether XX had a nonfunctioning irreparable rotator cuff with and without glenohumeral arthropathy (arthritis), no evidence of rheumatoid arthritis with rotator cuff deficiency nor was there evidence of failed hemiarthroplasty or failed total shoulder arthroplasty with a repairable rotator cuff deficiency. XX. XX had a history of comminuted, displaced fractures of the proximal humerus, and XX was not over the age of XX. Furthermore, the physician did not provide any additional information regarding XX limited functional demands nor was there evidence that XX. XX had intractable pain that had not responded to conservative treatments for at least six months prior to requesting surgery. Moreover, the physician must provide evidence that XX. XX had an adequate deltoid function, an adequate passive range of motion to obtain functional benefit from the prosthetics in addition to having sufficient residual bone to permit from the fixation of the implant and no evidence of shoulder infection or severe neurologic deficiency. Although XX. XX met the BMI criteria, the remaining criteria were not met. There was mention of XX. XX having received a steroid injection in mid-February. However, there was no reference to XX response to this treatment, no history of medication use identified within the recent clinical documents, and no evidence that XX. XX had attempted a recent course of physical therapy or home exercise program to help facilitate improved functionality. In addition, the physician did not address the remaining criteria listed within the guidelines to support that XX. XX either met the criteria or had any exceptional factors that would warrant the proposed surgery as an outlier to the guidelines. Based on these findings, XX. XX was not a candidate for the requested surgery. In accordance with the previous denial, the request for right reverse total shoulder arthroplasty was noncertified. Regarding the postop shoulder immobilizer, the request was not supported. The primary surgical procedure had not been authorized at the time. The physician did not elaborate on what type of immobilization XX. XX would have necessitated following the surgery with no confirmation of this as to include a postoperative abduction pillow sling or a separate type of immobilization device. As such, in accordance with the previous denial, the request for postoperative shoulder immobilizer was noncertified.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The ODG recommends reverse shoulder arthroplasty for nonfunctioning irreparable rotator cuff tears with or without glenohumeral arthropathy, rheumatoid arthritis with rotator cuff deficiency, failed hemiarthroplasty or failed total shoulder arthroplasty with irreparable rotator cuff deficiency, or comminuted displaced fractures. The provided documentation indicates a previous history of a rotator cuff repair with evidence of high-grade partial-thickness tears of the supraspinatus and infraspinatus tendons on MRI. There is no indication that the high-grade partial-thickness rotator cuff tears are irreparable, and as such, the proposed right reverse total shoulder arthroplasty and postoperative shoulder immobilizer are not 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 and Environmental Medicine

Case Number: XXX Date of Notice: 06/28/18

☐ AHRQ-Agency for Healthcare Research and Quality Guidelines

☐ DWC-Division of Workers Compensation Policies and 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 and Treatment Guidelines

ODG, 2018: Shoulder
Reverse shoulder arthroplasty (RSA)
Recommended as indicated below.
See also Arthroplasty (shoulder); Arthroscopic debridement (for shoulder arthritis); and Surgery for rotator cuff repair. For average hospital LOS if criteria are met, see Hospital length of stay (LOS).
ODG Indications for Surgery™ -- Reverse Shoulder Arthroplasty:
Technical considerations include concepts of newer implant designs incorporating lateral offset, 135 degree humeral cup inclination, and larger glenospheres, with or without bone cement.
• Non-functioning irreparable rotator cuff with or without gleno-humeral arthropathy (arthritis); OR
• Rheumatoid arthritis with rotator cuff deficiency. OR
• Failed hemiarthroplasty or failed total shoulder arthroplasty with irreparable rotator cuff deficiency; OR
• Comminuted, displaced fractures (3 or 4 part) of the proximal humerus in older population (65 years or more). &
• Meets all of the following criteria:
- Limited functional demands; &
- Intractable pain that has not responded to conservative therapy (including NSAIDs, intra-articular steroid injections, and physical therapy) for at least 6 months, unless acute fracture; &
- Adequate deltoid function; &
- Adequate passive range of motion to obtain functional benefit from the prosthetics; &
- Residual bone permits firm fixation of the implants; &
- No evidence of shoulder infection; &
- No severe neurologic deficiency; &
- Body Mass Index less than 40, with documented significant weight loss effort for BMI>35, unless acute fracture; &
- If rheumatoid arthritis, tried and failed anti-cytokine agents or disease modifying anti-rheumatic drugs, unless acute fracture.

☐ Pressley Reed, the Medical Disability Advisor

☐ Texas Guidelines for Chiropractic Quality Assurance and 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)

Appeal Information

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.