

Clear Resolutions Inc.

An Independent Review Organization
7301 Ranch Rd 620 N, Suite 155-199
Austin, TX 78726
Fax: 512-519-7316

Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 22, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left shoulder arthroscopy with manipulation and glenohumeral capsulectomy and possible rotator cuff repair if found to be torn.

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

MD, 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 or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity exists for left shoulder arthroscopy with manipulation and glenohumeral capsulectomy and possible rotator cuff repair if found to be torn.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 11/4/08, 11/17/08
ODG-TWC, Shoulder
, 10/25/07-12/1/08
MRI of Left Shoulder, 11/12/07, 5/27/08

, ., MD, 1/15/08, 5/6/08
, PA, 2/19/08
Operative Report, 3/3/08
, MD, 4/25/08
, MD, 5/22/08, 7/9/08, 8/12/08, 10/24/08
, MD, 10/7/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx- year-old female injured on xx/xx/xx with an extension injury and a pop in her left shoulder. The original MRI scan showed a type 2 acromion. An MRI scan on 05/27/08 showed some fatty infiltration of the supraspinatus and infraspinatus muscles without tears. There was some concern for a viral neuritis. An EMG/nerve conduction study was performed and while incomplete, did not document such a problem. Range of motion has been documented as being less. The patient has been seen by Dr. and Dr. and the patient also had a second opinion with Dr. who recommended surgery. There have been injections for treatment as a positive indication for this procedure. She had sympathetic block, which gave her no relief. She has had physical therapy. She has had extensive conservative care. Current recommendation is for diagnostic arthroscopy with decompression and rotator cuff repair, if found.

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

The medical records provided for review demonstrate that this patient has an acromioclavicular hypertrophy, osteophytic spurring, and type 2 acromion, and that this is compatible with the insertional tendinopathy seen. There are many indications within the medical record to indicate that this patient is not a symptom magnifier. The request conforms to the criteria outlined in the ODG Guidelines. The reviewer finds that medical necessity exists for left shoulder arthroscopy with manipulation and glenohumeral capsulectomy and possible rotator cuff repair if found to be torn.

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)