

US Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Feb/20/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient Right Shoulder Acromioplasty/Distal Clavicle Resec RCR (23412, 23120, 23130)

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

M.D., board certified in 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines

Adverse Determination Letters, 12/15/08, 1/13/09

Chart of Providers, , undated

Radiology, 2/1/06

Dr. , MD, 2/2/05

CT Scan, 4/10/06

Operative Report, 6/5/06

Dr. , MD, 9/27/06

MRI Right Shoulder, 12/1/06

Operative Report, 3/4/08

Dr. MD, 6/3/08, 7/1/08, 9/2/08, 10/21/08, 11/11/08, 12/2/08,

Dr. MD, 6/24/08

MR 6/25/08

, 1/9/09

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who is approximately 12 months post right shoulder arthroscopic rotator cuff repair with distal clavicle resection and acromioplasty with ongoing symptoms. There is electrodiagnostic evidence of a right C6 radiculopathy. A postoperative MR arthrogram was performed on 06/25/08, which was limited due to motion artifact but with some suspect partial tear in the distal supraspinatus tendon. The current request is for repeat shoulder arthroscopic surgery.

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

The relationship of the C6 radiculopathy to the shoulder complaints has not been documented, and the reasons for his ongoing complaints are not clearly explained in the medical records. The need for repeat shoulder surgery of an identical nature to that performed approximately 12 months ago is also not explained in the medical record. Based upon the ODG Treatment Guidelines, there is no support for this repeat surgery, and the physician provider has not provided within his medical records the medical necessity for this surgery. There is no explanation in the records why the surgery should be approved and the Guidelines ignored. The reviewer finds that medical necessity does not exist for Outpatient Right Shoulder Acromioplasty/Distal Clavicle Resec RCR (23412, 23120, 23130).

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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