

SENT VIA EMAIL OR FAX ON
Jan/19/2009

Independent Resolutions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (817) 349-6420
Fax: (817) 549-0311
Email: rm@independentresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/19/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right shoulder arthroscopy, subacromial decompression, distal clavicle excision, possible rotator cuff repair with removal of calcific tendinitis deposits

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

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Office notes, Dr., 07/10/07, 07/20/07, 11/09/07, 03/20/08, 05/08/08

MRI right shoulder, 07/17/07

Physical therapy right shoulder, 07/24/07 to 8/17/07

Office notes, PA-C, 08/10/07, 08/24/07, 12/07/07, 04/15/08

Physical therapy notes, 08/07/07 to 9/14/07

Office note, Dr., 07/08/08

Office notes, Dr., 09/05/08, 10/03/08

Office note, Dr., 11/03/08

PATIENT CLINICAL HISTORY SUMMARY

This is a xx year old female with complaints of right shoulder pain. The MRI of the right shoulder from xx/xx/xx showed minimal supraspinatus insertional tendinopathy without evidence for rotator cuff tendon tear. The right shoulder was injected on xx/xx/xx, 03/20/08

and 07/08/08 for temporary relief. The plain x-rays from 07/08/08 showed calcification of the insertion of the rotator cuff. The claimant has been treated with physical therapy, antiinflammatory medications and multiple providers for both shoulder and neck pain. Dr. evaluated the claimant on 11/03/08 for progressive pain with overhead activity and pain while sleeping on affected side. Examination revealed positive impingement sign, positive cross over arm adduction, tenderness over acromioclavicular joint and biceps tendon. Internal and external rotation with arm at side revealed moderate crepitations with palpable click within the subacromial space. Rotator strength testing both in forward elevation, abduction and external rotation showed moderate strength deficit although no obvious substitution noted. Dr. reviewed the radiographs. Diagnosis was right shoulder significant rotator cuff tendinopathy, possible rotator cuff tear, and calcific tendonitis post traumatic impingement syndrome and acromioclavicular internal derangement.

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

The requested right shoulder arthroscopy, subacromial decompression, distal clavicle excision and possible rotator cuff repair with removal of calcific tendinitis deposits is medically necessary based on review of this medical record.

This claimant has had pain since June 2007 and has been treated conservatively with activity modification, home exercises, physical therapy, anti-inflammatory medication, and cortisone injections.

The 11/03/08 office visit of Dr. is comprehensive. It goes over the entire treatment and contains positive physical findings to correlate with impingement, acromioclavicular joint symptoms, and possible rotator cuff tearing.

ODG guidelines document the use of acromioplasty in patients who have impingement and have failed conservative care. They also discuss the use of rotator cuff repair in patients who have ongoing pain, limitation in function, abnormal diagnostic testing, and lack of improvement to appropriate conservative care.

This reviewer's medical assessment is that these records indicate the claimant has been thoroughly worked up and treated conservatively, and the requested surgical intervention is medically necessary to deal with her ongoing signs and symptoms of rotator cuff tendinitis, impingement, acromioclavicular joint arthritis, and possible rotator cuff tear.

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)