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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/07/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Arthroscopy of right shoulder with subacromial decompression; arthroscopy of joint (29826, 29999)

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

M.D., 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

ODG Guidelines and Treatment Guidelines

W/C Request for Medical Care: xx/xx/xx

Employers 1st Report of Injury or Illness: xx/xx/xx/xx

Associated Statement – W/C: 11/28/08

Healthcare System – Emergency Records: xx/xx/xx (x21 pages)

Rt. Shoulder & Rt. Humerus X-Rays: 11/28/08

Work/School Excuse: 11/28/08

Lab Reports: 11/28/08

Release of Protected Health Information Form: 11/29/08

Dr. – Excuse Note: 12/01/08

Health History: 12/03/08

Medical Group Visit Summary: 12/03/08; 12/09/08; 12/16/08

Dr. (D.C.) Office Records: 12/17/08; 01/05/09; 01/08/09; 01/12/09; 01/28/09; 02/18/09; 03/23/09; 04/06/09; 05/27/09

Notice of Disputed Issue(s) and Refusal to Pay Benefits: 12/30/08

Dr. Office Records: 01/06/09; 02/03/09

Physical Therapy Notes: 01/06/09 to 01/27/09 (9 visits)

MRI Rt. shoulder: 01/07/09

Dr. Office Records : 02/16/09; 05/21/09

Rt. Shoulder X-Rays: 02/16/09

Diagnostic Services – Computerized Muscle Testing and ROM study, Rt. shoulder: 02/16/09 & 05/21/09
Daily PT Notes: 03/17/09 & 03/23/09
Surgery Reservation Sheet: 05/26/09
Peer Review – Dr. 05/29/09
Supplemental Report of Injury: 06/06/09
Peer Review – Dr. 06/08/09
Independent Review Organization Summary: 06/22/09

PATIENT CLINICAL HISTORY SUMMARY

This left hand dominant claimant sustained a pulling and lifting type injury to the right arm on xx/xx/xx with an initial diagnosis of rotator cuff sprain following evaluation in the emergency room on xx/xx/xx. Right shoulder and humerus x-rays were normal. The claimant was later diagnosed with impingement syndrome of the right shoulder and treated conservatively with physical therapy, anti-inflammatories, analgesics, muscle relaxants and modified duty. A right shoulder MRI was completed on 01/07/09 that revealed supraspinatus and infraspinatus tendinosis with mild to moderate impingement of the supraspinatus by the acromioclavicular joint.

An orthopedic referral was made after a 3 month history of persistent pain and a cortisone injection was given on 02/16/09 following right shoulder x-rays that were again normal. Additional physical therapy post injection was completed with improvement in internal and external rotation noted on 03/23/09 physical therapy progress notes.

The claimant followed up with Dr. on 05/21/09 for continued pain and restricted range of motion and muscle weakness. The claimant was noted to have exhausted 6 months of conservative measures including physical therapy, oral and topical medications, activity modifications, a steroid injection and modified duty. A right shoulder arthroscopy was recommended for a diagnosis of right shoulder impingement and chronic rotator cuff tendinitis.

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

The requested right shoulder arthroscopy with subacromial decompression and joint arthroscopy are medically necessary based on review of this medical record.

This claimant was injured in xx/xxxx and has seen a number of different physicians for right shoulder pain. The claimant has been treated with physical therapy, activity modification, home exercises, anti-inflammatory medication, pain medication, and a subacromial injection without good long-term improvement. The claimant has undergone an MRI documenting rotator cuff tendinitis. The surgeon has described positive physical findings to include impingement, tenderness, and weakness.

ODG guidelines document the use of arthroscopic surgery with acromioplasty in patients who have failed three to six months conservative care, have positive physical findings to include tenderness, weakness, and impingement sign, have ongoing subjective complaints, and have positive diagnostic testing. In this case, the claimant has an MRI documenting tendinitis, which is consistent with impingement, as well as the records document conservative care with failure. Therefore, the requested surgical intervention to include arthroscopy, subacromial decompression, and joint arthroscopy are medically necessary. The reviewer finds that medical necessity exists for Arthroscopy of right shoulder with subacromial decompression; arthroscopy of joint (29826, 29999).

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)