

US Decisions Inc.

An Independent Review Organization
71 Court Street
Belfast, Maine 04915
Phone: (512) 782-4560
Fax: (207) 470-1085
Email: manager@us-decisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Oct/19/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right shoulder arthroscopy, distal clavicle resection, 29824, 29826, 29999

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, 9/22/09, 9/10/09

MD, 8/21/09, 7/7/09, 4/16/09, 1/28/09, 12/9/08, 11/4/08, 8/11/08

MD, 8/6/09

DC, 6/20/08

Therapy & Diagnostics, 8/21/09, 4/16/09, 12/9/08, 11/4/08, 8/11/08

X-Ray, Right Shoulder, 8/11/08

X-Ray, Cervical Spine, 8/11/08

MRI Right Shoulder, 8/7/09

Summit Diagnostics, 7/30/08

Right Shoulder MRI, 7/16/08

Cervical MRI, 7/16/08

Bone & Joint Surgery, 2007

Operative Report, 1/20/09

Cervical ESI, 10/1/08

PATIENT CLINICAL HISTORY SUMMARY

This is an injured worker who, according to history, has a cervical herniation at C5/C6. He has had a previous arthroscopic surgery in January 2009. He has had postoperative therapy and has had progressive loss of range of motion noted. He has seen a Designated Doctor, who recommended manipulation under anesthesia for the loss of range of motion. It would

appear from the evaluations by the various physicians that he initially postoperatively had a reasonable range of motion and then developed loss of range, notwithstanding participating in physical therapy. It is stated by the Designated Doctor that he had flexion on the effected side of only 70 degrees as opposed to 170 degrees on the other side. He had abduction of 80 degrees versus 170 degrees, and internal rotation of 50 degrees versus 70 degrees. Similar figures are reflected in the report by Dr. as far as abduction is concerned, though there is little mention of forward flexion after the surgery. Furthermore, there is no explanation that we have found within the medical records as to why the particular surgical approach was chosen. However, current recommendation is for arthroscopy and distal clavicle resection.

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

This patient underwent a shoulder arthroscopy in January 2009 as mentioned above and did relatively well initially but subsequently developed loss of range of motion. He has had a repeat MRI scan, which does not document a rotator cuff tear. He does not meet ODG Guidelines for a shoulder arthroscopic procedure with repeat acromioplasty and clavicle resection. While he has had sufficient nonoperative care, there is no documentation of night pain. There is also no documentation of relief, or at least temporary relief, with injection. The range of motion of this patient is such that it also fails to meet the criteria for inclusion per Official Disability Guidelines and Treatment Guidelines. It would appear that further investigation and treatment to satisfy this criteria would be necessary. It is for this reason the previous adverse determination could not be overturned. The reviewer finds that medical necessity does not exist for Right shoulder arthroscopy, distal clavicle resection, 29824, 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)