

US Decisions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/16/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left shoulder arthroscopy 29824, 23130, 23120, 29826, 29823, 29821

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Dr. 03/25/10, 04/07/10, 04/28/10, 05/27/10, 06/30/10

MRI, 04/23/10

IMO Determinations, 06/04/10, 06/24/10

Therapy 03/26/10 - 05/28/10

Official Disability Guidelines 2010. 15th Edition, Shoulder Chapter

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male injured on xx/xx/xx. On 03/25/10, Dr. reported the claimant was injured when he was carrying 85 pounds into an air cab and felt a pop in his knee and left shoulder. He had shoulder pain near the scapula with clicking and popping that was made worse with reaching. There was tenderness of the left subacromial space. He had a mild decrease in motion with no laxity or crepitus. There was normal upper extremity strength. Dr. noted a positive left shoulder impingement and apprehension. X-rays of the left shoulder showed no bony abnormality. Mobic and therapy were recommended. The 04/23/10 MRI of the left shoulder showed moderate tendinitis of the periphery of the supraspinatus. There was minimal subchondral edema of the humeral head that appeared degenerative and a type II acromion.

On the 04/28/10 follow up, Dr. reported there was ongoing shoulder pain. The examination documented normal motion with no crepitus or laxity. There was tenderness of the subacromial space. Normal strength was documented in the upper extremities. Additional therapy was ordered and surgery was discussed. By 05/27/10, the claimant was unchanged and surgery was recommended. Surgery was denied on peer review 06/04/10. A 06/16/10 note from Dr. noted the claimant had had therapy, anti-inflammatory medication and modified activity. He also noted there was current full motion and strength but there was persistent pain that would warrant surgery. A second 06/24/10 Peer Review also denied the request for surgery.

On 06/30/10, Dr. reported the claimant had shoulder pain, stiffness and impaired motion. At that time, active flexion was 120 degrees, extension 35 degrees, abduction 140 degrees, external rotation 65 degrees, and internal rotation to the lateral hip. The claimant had a weak rotator cuff and tenderness at the subacromial space. A steroid injection was given.

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

This is a gentleman who was injured on xx/xx/xx. The medical records of Dr. document ongoing left shoulder pain complaints and the claimant has had physical therapy, anti-inflammatory medication, activity modification. The 06/16/10 visit indicates he has full range of motion and strength but has pain. The 06/30/10 visit indicated the claimant was given a steroid injection and surgery was scheduled, however there is no documentation of whether or not the claimant had any improvement with the cortisone injection. ODG Guidelines for surgery document the use of arthroscopic acromioplasty and debridement in claimants who have three to six months of worth of conservative care to include an injection and that have failed appropriate conservative care, have abnormal diagnostic testing, and have ongoing complaints and findings. In order to satisfy the ODG in this case it would be necessary to know whether the steroid injection helped this claimant prior to scheduling surgery. The reviewer finds that medical necessity does not exist at this time for Left shoulder arthroscopy 29824, 23130, 23120, 29826, 29823, 29821.

Official Disability Guidelines 2010. 15th Edition, Shoulder Chapter

Surgery for Impingement

ODG Indications for Surgery -- Acromioplasty

Criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome (80% of these patients will get better without surgery.

1. Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS
2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees. AND Pain at night. PLUS
3. Objective Clinical Findings: Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS
4. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of impingement.

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)