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Notice of Independent Review Decision

DATE OF REVIEW: 1/26/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The services under dispute include a left shoulder claviclectomy, decompression and possible rotator cuff repair (29824, 29826, 29827).

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 15 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of a left shoulder claviclectomy, decompression and possible rotator cuff repair (29824, 29826, 29827).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Dr.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr.: progress reports 8/4/08 through 12/14/09 by Dr., 7/28/08 medical report by Dr., 9/17/09 cervical MRI report and operative report 8/19/08.

notes by Dr. 10/6/09, notes by Dr. (no date and 2/25/09 through 5/19/09), 7/28/09 peer review report, 5/20/09 lab report, 3/25/09 peer review report, handwritten 12/19/08 report, 10/7/08 through 12/9/08 PT progress notes, treatment log 2/21/07 through 12/9/08, exercise flow sheet 11/26 through 12/9/08, 4/22/08 and 11/26/08 initial PT eval reports, discharge reports 10/7/08 and 4/19/07, 9/29/08 shoulder PT initial eval report, plan of care 9/29/08, MD reports 1/16/07 through 7/18/08, 6/30/08 arthrogram and MR arthrogram report of left shoulder, 2/26/07 to 5/6/08 progress reports by, 3/28/08 peer review report, 5/29/07 peer review report, 3/7/07 to 4/5/07 PT progress reports from, procedure log 3/21 to 4/18/07, rehab exercise program notes 3/29/07 to 4/5/07, eval summary 3/21/07, discharge report 3/19/07, DWC 69 report 3/15/07, various DWC 73 forms, eval report by Dr. 3/15/07, script 3/14/07, initial plan of care 2/21/07, initial eval PT 2/21/07, pt intake survey 2/21/07, 2/9/07 script for eval and treat, 2/8/07 MR and MR arthrogram for left shoulder report, MD exam reports 12/14/05 to 12/14/06, notes by Dr. 8/4/06 to 8/14/06, operative report 8/4/06, DWC 69 and report 6/9/08, 11/30/05 left shoulder MRI report, W. Webb MD report 11/22/05 and report of injury report xx/xx/xx.

We did not receive the ODG Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male injured on xx/xx/xx at work. Underwent left shoulder open distal clavectomy and subacromial decompression 8/4/06 by Dr. and released to return to work on 12/14/06. Continuing pain led to the patient seeking care from Dr. on 1/16/07. An MRI arthrogram on 2/8/07 revealed intact rotator cuff and labrum with AC joint changes. The patient was seen by Dr. and underwent arthroscopy of the left shoulder on 8/19/08, was found to have an intact rotator cuff, pristine articular surfaces glenoid and humerus, and underwent CA ligament resection and subacromial decompression. The patient continued to complain of pain and underwent pain management until he was released for a narcotic agreement violation. An MRI of the cervical spine, shoulder and EMG are normal on 10/19/09 note by Dr..

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

The patient has no evidence of a rotator cuff tear on the MRI or on an arthroscopic exam by Dr.. He has had an open distal clavectomy and two subacromial decompressions and bursectomies. The previous surgeon, Dr., has recommended that the patient be placed at MMI, and sent for an impairment rating and pain management. No imaging findings of positive evidence of impingement are present.

According to the ODG: Acromioplasty:

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

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. This patient does not meet all of the criteria; therefore, the procedure is not medically necessary based upon the records presented.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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)