

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 23, 2009 AMENDED: JANUARY 20, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed shoulder surgery code: 29823 and 29825

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of medicine.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
719.41	29823, 29825		Prosp	1					Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-16 pages

Respondent records- a total of 94 pages of records received to include but not limited to:
TDI letter 12.3.09; xxxxx letter 9.22.09, 11.9.09, 11.18.09, 11.30.09; email to 11.9.09-11.30.09;
Clinic 9.29.09, 11.3.09; MRI shoulder 3.10.09; xxxxx notes 3.31.09-4.29.09; report 6.2.09, PA-

C; Reviews 11.9.09-11.30.09 reports; XChange reports 9.22.09-11.30.09; xxxxx
xxxxx notes 9.8.09-9.29.09; x rays shoulder 3.3.09

Requestor records- a total of 44 pages of records received to include but not limited to: Clinic
8.20.09-11.3.09; XChange reports 11.9.09-11.30.09; MRI shoulder 3.10.09; x rays
shoulder 3.3.09; xxxxxx notes 9.8.09-9.29.09; report 6.2.09, PA-C; xxxxxx notes 3.31.09-
4.29.09;

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient sustained an on the job injury on xx/xx/xx.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

As noted in the Division mandated Official Disability Guidelines (Updated November 2009) the criterion for a rotator cuff tear repair is

“1. Criteria for rotator cuff repair with diagnosis of full thickness rotator cuff tear AND cervical pathology and frozen shoulder syndrome have been ruled out

2. Subjective Clinical Findings: Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. PLUS

3. Objective Clinical Findings: Patient may have weakness with abduction testing. May also demonstrate atrophy of shoulder musculature. Usually has full passive range of motion. PLUS 3. Imaging Clinical Findings: Conventional x-rays, AP and true lateral or axillary views. AND Gadolinium MRI, ultrasound or arthrogram shows positive evidence of deficit in rotator cuff.”

The criterion for an acromioplasty and sub-acromial decompression is

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.

There is clear MRI evidence of a complete rotator cuff tear and cervical pathology has been ruled out. The range of motion of the shoulder is far in excess of what would be required to support the acromioplasty request. The degenerative pathology noted in the AC joint is not a function of this reported mechanism of injury.

While noting the extensive pre-existing tendinopathy, there is a rotator cuff tear. The second aspect of this is that the request is addressing ordinary disease of life degenerative changes in the acromio-clavicular joint.

The rotator cuff repair and decompression aspects of the shoulder surgery have already been approved by the URA This request is for the medical necessity of arthroscopic debridement and a distal clavicle resection. As noted, there is pathology to be addressed that requires surgery; but the arthroscopic debridement and distal clavicle joint resection are not supported by the ODG

Therefore, the denial is upheld..

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
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)