

Clear Resolutions Inc.

An Independent Review Organization
7301 RANCH RD 620 N, STE 155-199A
Austin, TX 78726
Phone: (512) 772-4390
Fax: (512) 519-7316
Email: resolutions.manager@cri-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Mar/01/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Right shoulder arthroscopy with subacromial decompressions (29826, 29823, 29999, possible 23412, 29807)

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)

The reviewer finds that medical necessity exists for right shoulder arthroscopy with subacromial decompressions 29826, 29823, possible 23412, 29807. The reviewer finds that medical necessity does not exist for 29999.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines
Adverse Determination Letters, 01/29/10, 01/20/10
Employer First Report of Injury xx/xx/xx
Dr. OV 11/03/08
Dr. OV 11/17/08, 11/21/08, 12/03/08
Dr. OV 12/12/08, 01/23/09, 02/20/09, 05/01/09, 06/05/09
Dr. OV 06/22/09, 07/03/09
Dr. Ov 10/06/09, 11/05/09
MRI right shoulder 12/01/08
Employee request to change treating doctor form 06/30/09
Peer Reviews, 01/20/10, 01/29/10
Employee Claim 06/18/09
Manual Muscle Testing and Range of Motion exam 10/06/09
Surgery Reservation sheet 01/13/10
Attorney letter 02/17/10

PATIENT CLINICAL HISTORY SUMMARY

This is a male who reportedly sustained a slip and fall on xx/xx/xx which resulted in right shoulder pain. The records indicate that the claimant was initially diagnosed with right

shoulder strain and treated conservatively with medication, physical therapy and work modifications. MRI of the right shoulder performed on 12/01/08 showed impingement syndrome with minimal tendinosis of the rotator cuff. Follow up physician records in December 2008 noted that the claimant had significant loss of motion with positive impingement of the right shoulder. Continued right shoulder pain was reported throughout 2009 despite conservative care that included medications, physical therapy, four shoulder injections, and work restrictions. X-rays revealed no bony abnormalities and no fractures. The diagnosis remained right shoulder impingement syndrome. Right shoulder arthroscopy was recommended.

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

The ODG guidelines recommend surgery for impingement syndrome, i.e., subacromial decompression based on failure of conservative care generally up to three to six months, subjective complaints of findings on examination that are corroborated by physical exam findings. The records request a series of procedures to be performed which are typical for subacromial decompression. They would all be indicated in this individual's case, excepting the 29999 unlisted procedure, as there is no clear discussion as to what the purposes of this particular code would be. Absent the rationale for 29999, the request for that code is not medically necessary.

The reviewer finds that medical necessity exists for right shoulder arthroscopy with subacromial decompressions 29826, 29823, possible 23412, 29807. The reviewer finds that medical necessity does not exist for 29999.

Official Disability Guidelines Treatment in Worker's Comp 2010 Updates, Shoulder: Surgery for impingement syndrome

Surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery

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)