

US Decisions Inc.

An Independent Review Organization
2629 Goldfinch Dr
Cedar Park, TX 78613-5114
Phone: (512) 782-4560
Fax: (207) 470-1085
Email: manager@us-decisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: March/02/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

OUTPATIENT LEFT SHOULDER ARTHROSCOPY/DIAGNOSTIC TO INCLUDE 29805

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, Chapter shoulder, diagnostic arthroscopic

Prospective/Concurrent Review Determination, 1/15/10, 12/29/09

MRI left shoulder 01/03/07

Dr. office note 12/11/09

Office notes Dr. 02/27/07, 01/15/08, 02/12/08

Electromyography 03/06/07

MD, DDE 04/16/07

MRI left shoulder 05/2/07

Pre MRI arthrogram left shoulder 05/22/07

Post arthrogram MRI left shoulder 05/22/07

Operative report Dr. 09/14/07

Dr. RME 06/05/08

Office note Dr. 11/10/08

Electromyography 12/03/08

Office note Dr. 12/08/08

Left shoulder arthrography and CT 01/22/09

Office note Dr. 03/30/09

Office note 04/23/09 Dr.

Dr. RME 06/02/09

Office note Dr. 06/08/09

Office note 08/20/09

Dr. IMR 10/05/09
Office note Dr. 11/05/09
Peer review Dr. 12/29/09

PATIENT CLINICAL HISTORY SUMMARY

This is a male who is status post arthroscopy of the left shoulder, intra articular debridement and open rotator cuff repair performed on 09/14/07. Postoperatively, the claimant developed adhesive capsulitis. The 01/22/09 left shoulder arthrography and CT showed an intact supraspinatus tendon without full thickness tear or musculature retraction. CT disclosed small supraspinatus and infraspinatus muscles and about 60 percent fatty atrophy of the subscapularis muscles.

Suspected adhesive capsulitis with a small interarticular volume and axillary recess, presence of at least three small posterolateral capsular calcifications and an appearance of poor visualization of inter distinct capsular margin suggesting synovitis were reported. This appearance was particularly noticeable when compared to a normal examination. MRI imaging or MR study comparison was suggested to be able to better see and measure this claimant's posterior capsular low signal margins. A retained metallic anchor was located a few millimeters medial to the bicipital groove of superolateral subcortical humeral head was reported.

On 10/05/09, Dr. performed an independent medical examination. The claimant reported that he was unable to lie on his left side. The examination revealed severe atrophy of the anterior portion of the left shoulder with deltoid deterioration, marked difficulty with forward flexion and abduction of the left shoulder and good internal rotation and external rotation. Left shoulder flexion and abduction was to 60 degrees and 50 degrees of extension. Internal rotation was to 90 degrees, and external rotation was to 80 degrees. Acromioclavicular joint tenderness to palpation on left and severe atrophy of the left shoulder was reported. Dr. stated that the claimant had exhausted treatment and did not recommend surgery and should follow with an orthoped who specialized in shoulders. The claimant has been treated with physical therapy, home exercise program, work restrictions, Ultram, manipulation and light duty.

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

Based on the records provided for this review, there is nothing to support the medical necessity for outpatient left shoulder arthroscopy, diagnostic. The claimant has exhausted conservative care and has atrophy. The records indicate the claimant may have had a brachial plexus injury or cervical nerve root compression. This does not satisfy ODG criteria for left shoulder arthroscopy. Given the above issues, and consistent with evidence-based medicine ODG guidelines, the reviewer finds that medical necessity does not exist for OUTPATIENT LEFT SHOULDER ARTHROSCOPY/DIAGNOSTIC TO INCLUDE 29805.

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, Chapter shoulder, diagnostic arthroscopic

Recommended as indicated below. Criteria for diagnostic arthroscopy (shoulder arthroscopy for diagnostic purposes): Most orthopedic surgeons can generally determine the diagnosis through examination and imaging studies alone. Diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Shoulder arthroscopy should be performed in the outpatient setting. If a rotator cuff tear is shown to be present following a diagnostic arthroscopy, follow the guidelines for either a full or partial thickness rotator cuff tear.

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)