



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 5/3/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of right shoulder clavectomy, decompression, biceps tenodesis and RCR.

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. This 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 disagrees with the previous adverse determination regarding the prospective medical necessity of right shoulder clavectomy, decompression, biceps tenodesis and RCR.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
, Health Care and the patient.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: Patient Info Sheets – 3/4/10, Patient History Questionnaire, Acknowledgement, Communication Info, and Financial Policy – 3/3/10, Office Notes – 3/4/10-4/13/10; Approval of Change of Treating Doctor – 3/10/10; and Various DWC 73's.

Records reviewed from Health Care: Denial Letters – 3/17/10 & 3/31/10; MD Surgical Pre-cert Request – 3/10/10 & 3/24/10; MD MRI report – 12/18/09; MD notes – 1/14/10-2/22/10; prescription – 12/2/09-1/26/10; MD Office Notes – 11/20/09-2/22/10; Info Release, Patient Info, Auth. For Exam or Treatment – 11/20/09; Medical Centers Therapy Activity Status Report – 1/15/10 & 2/18/10, and Physician Activity Status Report – 11/20/09-2/22/10.

Records reviewed from the patient: letter - 4/19/10, surgery scheduler report- 3/23/10, Ortho Injury Specialists- office notes 3/10/10 to 4/19/10;

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

On xx/xx/xx, the claimant grabbed a hold of equipment that he was getting off, slipped and jolted his shoulder. He experienced a painful pop, as noted in the Attending Physician's records of 3-4-10. The impression was strain/impingement/rotator cuff tear. The subsequent note documented the persistent clinical condition of painful popping and catching, with a painful motion arc, weakness, positive drop arm and AC tenderness. The shoulder MRI was "sub-optimal." Non-operative treatment including injections and therapy had failed, as noted on 4-13-10. The 3-17-10 and 3-31-10 dated denial letters indicated that there was insufficient follow-up documentation of objective abnormalities on exam and of non-op. treatments.

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

The Attending Physician documentation is currently sufficient as it reflects the failure of non-operative treatment, the positive subjective and most recent abnormal objective physical findings. The equivocal MRI is suspicious for pathology that correlates with the original injury mechanism and the most recent clinical findings. (The 12-18-09 dated MRI revealed tendinopathy and AC impingement and in any event was suboptimal due to patient movement.) The persistent clinical problem has been well documented in the recent Attending Physician's records and the proposed procedures are reasonably required as per findings applicable at the time of surgery which is medically necessary as proposed.

According to the ODG Indications for SurgeryTM -- Acromioplasty:

Criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome...

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.

ODG Indications for Surgery™ -- Rotator cuff repair:

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 (Tenderness over the greater tuberosity is common in acute cases.) 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 deficit in rotator cuff.

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)