

Becket Systems

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/30/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

ASC Rt Shoulder Arthroscopy 29822 23120 23926 23412 29827 29825

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, Shoulder , 7/28/10, 7/12/10

Office notes, Dr., 01/21/10, 03/29/10, 04/26/10

PT notes, 01/27/10, 03/16/10

MRI right shoulder, 04/14/10

Dr., 07/12/10

Dr., 07/28/10

PATIENT CLINICAL HISTORY SUMMARY

This is a male with complaints of right shoulder pain with reaching behind his back and with activity. The MRI of the right shoulder, dated 04/14/10, showed mild tendinosis to the distal rotator cuff tendon or possible intrasubstance tear. A type II acromion without significant impingement was reported. Dr. saw the claimant on 04/27/10. The claimant reported discomfort with using his arm away from his body or with overhead. The examination revealed persistent tenderness over the acromioclavicular joint. Positive Neer and Hawkins impingement tests were reported. There was pain with speed testing. Forward flexion was to 150 degrees but with a painful arc past 125 degrees. Strength was 4+/5 with drop arm testing. Internal rotation was to the lumbosacral junction and painful. Dr. has recommended surgery. The claimant has been treated with physical therapy, TENS, home exercise program, light duty and Tylenol.

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

A review of the records provided supports the claimant reported lifting injury on xx/xx/xx, working as a. The claimant saw Dr. orthopedics, on 01/21/10. On examination the claimant has positive impingement with pain through abduction to 90 degrees, weakness, pain with Hawkins and Neer's. X-ray's were negative and recommended physical therapy and MRI with TENS Unit. Due to persistent symptoms the claimant continued with light duty work, home exercise program. An MRI of the right shoulder showed some tendinosis, possible small intrasubstance tear, but no significant impingement.

Surgery was recommended on 04/26/10. Dr. and Dr. did peer reviews and denied surgery due to the lack of physical therapy notes and documentation regarding conservative treatment.

Based on the information provided, the reviewer agrees with previous reviewers that ASC Rt Shoulder Arthroscopy 29822 23120 23926 23412 29827 29825 is not medically necessary. It is unclear if claimant has exhausted conservative care with anti-inflammatory medications or cortisone injections as a diagnostic therapeutic modality. Given the above issues and given a fairly normal MRI, evidenced based medicine and the ODG Guidelines, the reviewer is unable to recommend the proposed surgery as medically necessary. The reviewer finds that medical necessity does not exist for ASC Rt Shoulder Arthroscopy 29822 23120 23926 23412 29827 29825.

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapter shoulder, acromioplasty

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 (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-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)