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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/02/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

R Shoulder Open Distal Clavicle Resection of Fracture Osteophyte

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

M.D., Board Certified Orthopedic Surgery

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

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male injured his right shoulder on xx/xx/xx. He is employed making threads on pipes that are 12-18 inches in diameter. While tightening a bolt he felt sudden pain and has had weakness of the right shoulder. The claimant was initially seen at Xx Clinic by Dr. and diagnosed with right shoulder strain. He was referred to Dr. on 07/11/11. He underwent MRI of the right shoulder on 07/09/11. This study notes a full thickness supraspinatus tear with 2.4 cm of retraction, a small portion of supraspinatus remains attached anteriorly. There is no significant atrophy. There is a full thickness tear of infraspinatus inferiorly at the insertion site. Physical examination indicates he is 5'3' and weighs 156 lbs. He has positive severe supraspinatus sign for pain and weakness, positive drop arm test with severe weakness in thumb down position. He is neurovascularly intact. Radiographs were performed. His provider recommended that he continue home exercise program for range of motion, and physical therapy was not clinically indicated due to severe rotator cuff tear with retraction. He is on light duty pending surgical intervention. He was taken to surgery and seen in follow-up on 08/08/11. At this time he presents with some expected postoperative pain. He is reported to have undergone arthroscopic rotator cuff

repair on 08/04/11 as well as subacromial decompression and Mumford procedure. He was referred for physical therapy for the right shoulder range of motion 3x2. On 09/02/11, the claimant reported his motion is improving. He has soreness to the shoulder at night only, if he rolls on the shoulder. He is taking Ibuprofen 800 mg daily. He remains off work. On examination he has no signs or symptoms of infection. Range of motion indicates he can touch head with operative side hand. Abduction is to 80 degrees. Internal rotation is to L5. Sensation is intact to light touch. He is to continue physical therapy 3 times a week for 2 weeks. On 09/21/11, a follow up report states he was working light duty and going to therapy. He has some residual soreness, pressure, and limited motion. His range of motion is unchanged. He was referred for CT of shoulder.

CT shoulder study performed on 09/28/11 notes narrowing of acromiohumeral distance and moderate amount of fluid in subacromial subdeltoid bursa, possibly reflecting tear of rotator cuff. There is small ossific fragment along dorsal aspect of AC joint, possibly representing chronic fractured osteophyte. There are postoperative changes from previous subacromial decompression. Dr. saw the claimant in follow-up on 09/30/11. His range of motion is unchanged. He was continued on light duty and recommended to undergo a right shoulder open distal clavicle resection of fractured osteophyte.

Dr. Shirley performed the initial review on 10/06/11. Dr. non-certified the request noting there is no indication that any conservative treatment has been provided such as local injections. He opines the request is premature.

Dr. saw the claimant on 10/21/11. He has continued severe problems with his right shoulder. Most of the pain is reported to be in the AC joint. He is now noted to be having poor motion. On examination he has severe AC joint pain with axial load, positive pain with cross adduction, positive superior palpable hypertrophy at end of clavicle, positive scapular movement with humerus at 40 degrees abduction and 40 degrees forward flexion suggestive of adhesive capsulitis. Right shoulder open distal clavicle resection with manipulation under anesthesia is recommended.

Dr. reviewed a subsequent appeal request for surgery on 10/28/11. In his noncertification, he notes the patient has limited motion, although only one abduction measurement could be found in notes. He has some tenderness of AC joint and apparent small dorsal ossicles at distal clavicle. He noted the claimant has been undergoing therapy without any notes from therapy available. There is no indication that an attempt has been made to treat the distal clavicle problem with injection, and he notes if pain was relieved with injection then the described dorsal ossicles should not interfere with subsequent joint function.

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

This man sustained a massive retracted rotator cuff tear for which he underwent early surgical intervention. In the postoperative period he had improvement in pain, but no significant functional improvements in range of motion despite having undergone extensive postoperative physical therapy. Review of imaging studies indicates presence of potential bone fragment/ossicles, which may or may not be affecting range of motion. Clearly, the claimant has objective evidence of mechanical pathology, which warrants surgical intervention to restore function to injured shoulder as per the ODG. At this point in time the claimant's limitations are such that he can functionally not perform most activities. The reviewer finds there is a medical necessity for R Shoulder Open Distal Clavicle Resection of Fracture Osteophyte.

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)