

Notice of Independent Review Decision

DATE OF REVIEW: 12/29/2010
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

OP: Rt Shldr SAD, remove DC, decomp of
Acromioclavicular Jt 23120 29822

QUALIFICATIONS OF THE REVIEWER:

Orthopaedics

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)

OP: Rt Shldr SAD, remove DC, decomp of
Acromioclavicular Jt 23120 29822 Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Notice of air analyses, dated 12/20/2010
 2. Fax page dated 12/16/2010
 3. Request form by author unknown, dated 12/14/2010
 4. Notification of adverse determination MD, dated 12/3/2010
 5. Notification of adverse determination MD, dated 11/18/2010
 6. IRO request form by author unknown, dated unknown
 7. Notice of assignment, dated 12/20/2010
 8. Fax page dated 12/20/2010
 9. Request for preauthorization dated 11/15/2010
 10. New patient note by MD, dated 11/3/2010
 11. Visit note by MD, dated 9/16/2010 to 10/22/2010
 12. Plan of care by author unknown, dated 8/17/2010
 13. MRI joint upper extremity by author unknown, dated 8/12/2010
 14. Outpatient radiology – written orders by author unknown, dated 8/12/2010
 15. Plan of care PT, dated 7/20/2010
 16. Clinical note by author unknown, dated 7/19/2010
 17. X-ray by author unknown, dated 7/19/2010
 18. X-ray by author unknown, dated 7/14/2010
 19. Progress notes by author unknown, dated 7/14/2010 to 9/8/2010
 20. Official Disability Guidelines (ODG)
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INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a male whose date of injury is xx/xx/xx. Records indicate the injured employee was lifting a heavy vent hood when his right shoulder popped. MRI of the right shoulder dated 08/12/10 reported mild acromioclavicular hypertrophy and the study was otherwise unremarkable, specifically the rotator cuff appears normal. Injured employee was treated conservatively with physical therapy, activity modification/light duty, medications, and injection of the right shoulder with local anesthetic steroid. This gave temporary relief of pain but after several days the pain returned.

A request for right shoulder subacromial decompression, removal of distal clavicle and decompression of acromioclavicular joint was reviewed by Dr. on 11/18/10. Dr. determined the request to be non-certified, noting that the physical findings revealed tenderness over the acromioclavicular joint and crepitation in the subacromial space. There was positive Hawkin's sign and tenderness upon forward flexion with resistance on the acromion. MRI scan was unremarkable. Dr. noted the records indicated the injured employee had been treated conservatively with oral medications, steroid injection and physical therapy, but no physical therapy progress notes were attached and pain medications given were not included for review. It was further noted that the clinical information did not provide objective documentation of the injured employee's clinical and functional response from the mentioned steroid injection.

A reconsideration/appeal request was reviewed by Dr. on 12/03/10. Dr. again determined the requested surgery to be non-certified; noting the MRI study submitted for review indicated the injured employee had findings of mild acromioclavicular hypertrophy. Dr. further noted there were no significant positive physical examination findings to warrant the proposed procedure to include distal clavicle excision.

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

Based on the clinical data provided, medical necessity is not established for the proposed right shoulder surgery. Injured employee sustained a lifting injury to the right shoulder on xx/xx/xx. MRI scan performed 08/12/10 revealed only mild acromioclavicular hypertrophy and was otherwise unremarkable. Injured employee was treated conservatively without significant improvement. Examination of the left shoulder performed 11/03/10 reported some mild atrophy of the deltoid of the right shoulder compared to the left. A test of the range of motion of the right shoulder revealed abduction of 80 degrees with pain in the AC joint. Forward flexion was to 100 degrees with minimal pain. There was good external rotation without pain, and good internal rotation. There was tenderness over the AC joint with pain on palpation directly over the AC joint. Injured employee had good strength against resistance. Hawkin's sign was positive. Biceps was intact. There was no documentation of passive versus active range of motion. Per Official Disability Guidelines, criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome include: conservative care 3 to 6 months directed toward gaining full ROM, which requires both stretching and strengthening; subjective clinical findings to include pain with active arc motion 90-130 and night pain; objective clinical findings to include weak or absent abduction, and tenderness over the rotator cuff or anterior acromial area, and positive impingement sign and temporary relief with anesthetic injection; and imaging clinical findings showing positive evidence of impingement. While the injured employee was noted to have positive Hawkin's sign and temporary relief with injection, clinical examination noted no pain at night and pain with active arc motion 90-130 degrees. There was no objective evidence of impingement on imaging studies. As such medical necessity is not established for the proposed surgical procedure. The recommendation is to uphold the previous denials.

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 KNOWLEDGBASE
- 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)