

AccuReview
An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: JULY 10, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

O/P Right Shoulder RTC Acromioplasty and Mumford Procedure 29826 23420
23410

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

This physician is a Board Certified Orthopedic surgeon with 43 years of experience.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

3/2/11: D.O. evaluated the claimant. X-Rays show evidence of calcific tendinitis of the supraspinatus tendon and inferior osteophytes off the distal clavicle. PE:

Pain and tenderness at the anterior acromial region. He has weakness in abduction and forward flexion. There is a positive impingement sign and impingement test. Impression: Probable tear rotator cuff, calcific tendinitis of the supraspinatus tendon, and AC arthropathy.

3/8/11: MRI of the right shoulder was performed. Impression: Partial tear/tendinitis of the supraspinatus tendon. Minimal fluid in the subacromion subdeltoid bursa. Associated filling defect in the subacromion subdeltoid bursa measuring measures 16.93x4.24 mm, suggestive of loose body/ calcified bursitis. Moderate arthrosis of the acromio-clavicular joint with inferior osteophytes impinging on the supraspinatus tendon. Small subcortical cyst in the humeral head.

3/29/11: D.O. re-evaluated the claimant. Impression: Acute tear rotator cuff right shoulder with AC arthropathy.

4/14/11: M.D. performed a UR on the claimant. Rationale for Denial: There was no documentation provided with regard to the failure of the claimant to respond to conservative measures such as injections.

5/9/11: Per Dr. office note stated the claimant only received minimal relief from the subacromial injections and he has exhausted course of physical therapy.

5/10/11: M.D. performed a UR on the claimant Rationale for Denial: Lack of documentation of failure of conservative treatments and no clear documentation of objective findings.

5/13/11: PT note from.

6/3/11: D.O. re-evaluated the claimant. Impression: Partial tear rotator cuff with failed conservative care.

PATIENT CLINICAL HISTORY:

The claimant injured his right shoulder while moving a pallet jack.

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

The previous decisions are overturned per the ODG the claimant meets the criteria for surgical intervention. The claimant has undergone conservative care in the form of physical therapy & injections, has clinical findings on physical exams, and imaging findings of impingement in the right shoulder.

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. 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.

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)**