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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: May/05/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Left shoulder arthroscopic subacromial decompression, AC joint resection and possible rotator cuff repair 29826 29824 29827

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:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY
This is a male claimant who reportedly sustained a left shoulder injury on xx/xx/xx when a rail fell onto his shoulder. Diagnoses included left shoulder pain and left shoulder rotator cuff tendinitis. A left shoulder MRI performed on 07/09/10 showed mildly hypertrophic acromioclavicular (AC) joint arthritis and findings of rotator cuff tendinosis. A physician visit dated 10/06/10 revealed the claimant had had a left shoulder AC sprain and some impingement type pain from a fall, had had some physical therapy and was status post steroid injection in July 2010. Continued therapy was recommended. A therapy progress record dated 11/22/10 revealed the claimant reporting the ability to reach further above his head and reach further behind his back along with sleeping better, however, a follow-up physician record dated 11/24/10 noted the claimant with continued pain despite therapy and injection.

A shoulder evaluation was performed on 12/23/10, which noted the claimant with left shoulder pain despite pain medication, therapy and injection. An examination documented AC joint tenderness diffusely, some swelling and motion limited by pain. X-rays showed AC joint arthritis and type 2 acromion. The impression was degenerative joint disease AC joint with a differential diagnosis that included rotator cuff tear and labrum tear. A follow up physician record of 02/10/11 revealed the claimant with no change in symptoms.

The claimant reportedly desired surgery. An arthroscopic subacromial decompression, arthroscopic AC joint resection and possible rotator cuff repair was recommended.

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

The request for Left shoulder arthroscopic subacromial decompression, AC joint resection and possible rotator cuff repair 29826 29824 29827 is not medically necessary based on the records provided in this case.

If one looks towards the Official Disability Guidelines surgery for impingement syndrome, there should be positive findings of impingement on examination and temporary relief of pain with anesthetic injection. In this case the only physical examination findings provided are for an office visit dated 12/23/10. This visit documents AC joint tenderness, however it does not document impingement signs. There is no documentation of temporary relief of pain with anesthetic injection. Therefore per the Official Disability Guidelines this surgery -- Left shoulder arthroscopic subacromial decompression, AC joint resection and possible rotator cuff repair 29826 29824 29827 – is not found by the reviewer to be medically necessary at this time.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)