

Prime 400 LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Nov/08/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left Shoulder Partial Acromioplasty, possible RTC repair 23130 possible 23420

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

Official Disability Guidelines and Treatment Guidelines

Notification of adverse determination 09/16/11

Notification of adverse determination 08/18/11

Progress notes Dr. 06/16/11-10/14/11

MRI left shoulder 05/18/11

Designated doctor evaluation Dr. 09/14/11

Physical therapy evaluation 07/11/11

Request for preauthorization outpatient physical therapy 08/17/11

Physical therapy reevaluation 08/10/11

Utilization review request 08/15/11

Utilization review reconsideration request 08/29/11

PATIENT CLINICAL HISTORY SUMMARY

This case involves a female whose date of injury is xx/xx/xx. She reported injury as a result of cumulative stresses due to work, including heavy lifting. MRI of the left shoulder performed 05/18/11 revealed no evidence of full thickness rotator cuff tear, moderate degree of subacromial bursitis, supraspinatus tendinosis and peritendinitis, low grade intrasubstance tear at insertion of supraspinatus tendon, degenerative arthrosis of acromioclavicular joint with moderate degree of medial outlet stenosis, minimal degree of capsular synovitis with mild chondromalacia of the glenohumeral joint, no labral tear. She was treated with physical therapy, massage therapy, and ultrasound. She was also prescribed medications (Flexeril, Mobic) and activity modification -- light duty. On 08/12/11 she was evaluated for cervical strain and rotator cuff tear / impingement. She was noted to have impingement syndrome of left shoulder. She has been doing physical therapy for neck and shoulder. Her neck is doing somewhat better, but shoulder is still symptomatic. She complains of pain on abduction, flexion, extension and pain to direct pressure. There is no instability. On examination she

can flex the chin to touch chest. She can extend 30 degrees. She can rotate 60 degrees in either direction. She has lateral bending of 30 degrees in both right and left. Her shoulders can abduct to about 70 degrees, elevate to about 90 degrees. She has pain on abduction and external rotation and is tender in subdeltoid area. The claimant was recommended to undergo decompression of shoulder with acromioplasty and exploration of rotator cuff.

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

This woman reported cumulative stresses from work causing injury to her neck and left shoulder. MRI of the left shoulder revealed no evidence of full thickness tear with low-grade intrasubstance tear at insertion of supraspinatus tendon and moderate supraspinatus tendinosis and peritendinitis. Degenerative arthrosis of the AC joint was noted with moderate degree of medial outlet stenosis; minimal degree of capsular synovitis with mild chondromalacia of glenohumeral joint. She participated in physical therapy for approximately one month, and improvement was noted with increased range of motion of left shoulder in both flexion and abduction. Her flexion improved from 96 degrees on 07/11/11 to 140 degrees on 08/10/11, with abduction improving from 61 degrees to 155 degrees in same time period. Per ODG guidelines, there should be at least 3-6 months of conservative treatment prior to consideration of surgical intervention. It does not appear this patient has had an adequate course of conservative treatment. She is reported to have impingement syndrome, but there is no documentation of orthopedic testing including Neer, Hawkins or other indications of positive impingement on physical examination. At this time, the reviewer finds there is not a medical necessity for Left Shoulder Partial Acromioplasty, possible RTC repair 23130 possible 23420.

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)