



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 9/13/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of an outpatient left shoulder arthroscopy decompression (29826).

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of an outpatient left shoulder arthroscopy decompression (29826).

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee's left shoulder was injured in a truck driver rollover on xx/xx/xx. On 11/4/10, an MRI revealed edema/possible acromioclavicular joint injury. The Attending Physician records were reviewed, including most recently from 6/23/11. The claimant has a recurrent left shoulder pain, along with objective weakness. Treatment failure has included Physical Therapy (records from the late Fall, 2010, were reviewed), medications and injection. Denial letters noted the lack of any recent treatment (with medications and cortisone injection)

specifically detailing quantity and quality of response (or lack thereof) were not submitted for review.

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

Recent documentation of a painful arc of motion, positive impingement sign, and imaging revealing “positive evidence of impingement” (as per clinical guidelines applicable) has not been submitted. In addition, there has not been recent evidence of a detailed trail and detailed failure of a comprehensive non-operative treatment program/”conservative care, as per applicable guidelines. Therefore, the proposed procedures are not medically necessary at this time.

ODG Shoulder/Surgery for Impingement Syndrome:

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)**