

SENT VIA EMAIL OR FAX ON
Apr/25/2012

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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/25/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

OP Left Shoulder Arthroscopy w/Slap Repair/Distal Calviulectomy (Mumford) Arthro SAD w/Acromioplasty/Rotator Cuff Repair/Bicep Tenodesis

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

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

OD Guidelines

Request for IRO 04/13/12

Utilization review determination 02/24/12

Utilization review determination 03/26/12

Clinical records 01/05/12-02/27/12

Clinical note 02/08/12

MRI left shoulder 02/13/12

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is reported to have sustained work related injuries to his left shoulder on xx/xx/xx. It is reported that on the date of injury he was raising a large cable at a distance of about 80 feet. The cable slipped from his hands and he tried to grab it and felt a sudden pain and popping with weakness in the left shoulder. The claimant felt that his shoulder dislocated. It is reported that at the site of the accident a coworker pushed on the shoulder reducing it. He is reported to have had a similar episode that day. On 01/05/12 the claimant sought care from. He reports no prior shoulder injuries. On physical examination he is noted to be 67 inches tall and weighs 162 pounds. He is noted to have tenderness over the anterior aspect of the shoulder. Flexion is to 135 degrees. Abduction is 135 degrees. External rotation is 45. Internal rotation is to L5-S1. Motor strength is graded as 5/5. Apprehension test is positive. Anterior slide test is positive. Radiographs were unremarkable.

On 02/08/12 the claimant was seen by. The claimant is reported to have 4/10 pain which is improving. It is aggravated by activity and relieved by medications and physical therapy. Current medications include ibuprofen. On physical examination the claimant is reported to have positive O'Brien's, negative Speed's test, and positive SLAP test. Range of motion appears to be 180 degrees abduction and flexion, 30 degrees external rotation, 70 degrees internal rotation and 90 degrees external rotation.

The claimant was seen in follow-up by on 02/13/12. Physical examination is unchanged. The claimant was referred for MRI of the shoulder. This study performed on 02/13/12 notes that the long head of the biceps tendon is intact and normally located within the bicipital groove. The limited portions of a glenoid labrum visualized appear intact. There are minimal hypertrophic changes involving the acromioclavicular joint. The acromion has mild lateral down slope noted to be type 2 in shape. This results in some mild compromise/impingement of the subacromial space with minimal mass effect on the underlying supraspinatus muscle tendon. There is moderate edema and thickening involving the periphery of the supraspinatus tendon. There appears to be a partial thickness intrasubstance tear of 30% in severity. Intact fibers appear present with no full thickness tear or retraction. The claimant was seen in follow-up by on 02/15/12. There are no substantive changes in the claimant's physical examination. The claimant is subsequently recommended to undergo arthroscopic rotator cuff repair, SLAP repair, biceps tenodesis, partial claviclectomy and injection of platelet rich plasma gel.

The claimant was seen in follow-up on 02/27/12. There are no substantive changes in physical examination. The claimant is opined to have a rotator cuff tear, superior labral tear, anterior labral tear, and acromioclavicular joint sprain. He was again recommended to undergo surgical intervention.

The initial review was performed on 02/24/12 by who non-certified the request. It is noted that a telephonic consultation was performed with in which he delineated the failed non-operative treatments including medications, restricted activity, and physical therapy. He is reported to be planning treatment with an injection. indicated that the claimant did not meet Official Disability Guidelines.

The appeal request was reviewed by on 03/26/12 who subsequently non-certified the request noting that the claimant is less than three months post date of injury and that treatment to date has consisted of anti-inflammatories and physical therapy. He notes there is no indication that the claimant has undergone corticosteroid injections. He further notes that MRI does not suggest the presence of any pathology involving the biceps tendon and that there is no evidence of SLAP tear on imaging studies. He finds that given the lack of documentation to establish the failure of conservative treatment and that components of the request are not supported by the submitted imaging study the medical necessity was not established.

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

The request for outpatient left shoulder arthroscopy with SLAP repair, distal claviclectomy, arthroscopic subacromial decompression with acromioplasty, rotator cuff repair, and biceps tenodesis was not supported by the submitted clinical information and the prior utilization review determinations are upheld. The Official Disability Guidelines are very clear regarding the performance of surgical intervention on the shoulder, that a claimant must undergo an appropriate course of conservative treatment prior to the consideration of surgical intervention. The records fail to establish that the claimant has exhausted all conservative means prior to the request for surgery. Additionally it is noted that this appears to be a blanket request as it clearly requests multiple procedures that are not in evidence on imaging studies. Therefore the request would appear to be excessive. Based upon the submitted clinical information the claimant does not meet criteria per the Official Disability Guidelines.

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)