

Clear Resolutions Inc.

An Independent Review Organization
6800 W. Gate Blvd., #132-323
Austin, TX 78745
Phone: (512) 879-6370
Fax: (512) 519-7316
Email: resolutions.manager@cri-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Mar/27/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left Shoulder Acromioplasty

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

Request for IRO 03/08/12

Utilization review determination 12/30/11

Utilization review determination 01/17/12

Clinical records Dr. 02/22/11-02/21/12

MRI left shoulder 06/23/11

Physical therapy progress notes various dates

MRI right shoulder 02/15/11

MRI upper extremity 01/21/11

Operative report 10/05/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is reported to have sustained work related injuries on xx/xx/xx. He was operating a when he sustained an injury to his left wrist and right shoulder. He was loading a and the host was closed. When the claimant turned on the host the caps were on and he was struck with water pressure injuring his left wrist and right shoulder.

He was referred by Dr. for MRI of the wrist on 01/12/11 which notes a partially healed intraarticular fracture involving the distal radius with bone edema and surrounding soft tissue edema, moderate radiocarpal joint effusion and a small midcarpal joint effusion. There is a potential of a TFCC tear. Dr. referred the claimant for MRI of the right shoulder, which was performed on 02/15/11 and reports superior and anterior glenoid labral tears, and a large paralabral cyst extending medial into the suprascapular fossa of the glenoid margin. There is a glenohumeral joint effusion at subacromial subdeltoid bursitis. There is a full focal full thickness tear within the anterior half of the distal supraspinatus with an underlying grade 1 strain within the posterior supraspinatus and infraspinatus tendons. There is acromioclavicular joint arthrosis. The claimant was referred to Dr. on 02/22/11. This handwritten note indicates the claimant has wrist pain right shoulder pain. He notes a strong

jet of water, which threw the claimant against a truck. There is a note regarding fracture of the left ankle left wrist left radial styloid fracture. He is noted to be in a splint. He has shoulder pain with abduction. MRI was noted and discussed. Records indicate that on 06/23/11 the claimant was referred for MRI of the left shoulder which shows mild to moderate supraspinatus tendinopathy without tear. Clinical records suggest that the claimant has developed impingement of the left shoulder. Records indicate that the claimant was taken to surgery on 10/05/11 for and underwent a right shoulder acromioplasty rotator cuff debridement and excision of a distal clavicle. Post-operatively the claimant was referred for physical therapy. This note indicates that the claimant previously received injections in the past earlier in the course of his therapy.

On 02/21/12 it is reported that his right shoulder is better. He still has pain in the left shoulder. Surgery has been denied twice. The record contains a letter from Dr., which indicates that the claimant is reported to have had eight weeks of physical therapy and he is noted to have undergone intraarticular injection on 07/12/11 with three weeks of relief. He was recommended to undergo surgical intervention for impingement syndrome

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

This claimant initially sustained injuries to the right side of his body, which included the right wrist and right shoulder. There is no historical data establishing injury occurred to the left shoulder and it is unclear as to how this relationship developed. The claimant has undergone a course of conservative treatment which included a shoulder injection however this appears to be more focused on the right upper extremity for which the claimant was taken to surgery on 10/05/11. There is no apparent data contained in the clinical record which establishes that the claimant received focal treatment to the left shoulder. In addition to this, the documented physical examinations do not provide detailed information from which to establish the presence of an impingement syndrome given the benign appearance on MRI. The reviewer finds no medical necessity for Left Shoulder Acromioplasty.

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)**