

True Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Dec/12/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left Shoulder Arthroscopy, Subacromial Decompression, Distal Clavicle Excision, Rotator Cuff Repair

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

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Request for IRO 11/29/12
Receipt of request for IRO undated
Utilization review determination 10/25/12
Utilization review determination 11/20/12
Employer's first report of injury or illness
Employee report of injury incident 04/02/11
Clinical note 04/04/12
Clinical note 04/26/12-10/11/12
Peer review report 05/07/12
MRI left shoulder 05/09/12
Letter of appeal 10/30/12
Request for reconsideration 11/01/12
Clinical records 06/19/12-09/11/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was reported to have sustained work related injuries to his left shoulder. The claimant subsequently sought care at which time he was diagnosed with AC separation and a deltoid strain of the left shoulder and records indicated that the claimant was treated conservatively with oral medications and physical therapy.

On 04/26/12, the claimant was seen and was noted to have left shoulder pain with radiation into the scapula. On physical examination, range of motion of the neck revealed a positive Spurling test with extensor with extension and lateral bending to the left. This caused pain to radiate down the posterior aspect of the arm into the forearm region which caused dysesthesias in the dorsal forearm and in the radial aspect of the hand and on examination of the shoulder she had pain with overhead activity and was able to elevate to 165 degrees, external rotation was 65, internal rotation was to T10 and x-rays of the shoulder revealed acromioclavicular joint subchondral sclerotic change. A type 2 acromion was appreciated. The glenohumeral joint did not show any significant degenerative change. The claimant was diagnosed with left shoulder symptomology with impingement syndrome and a probable HNP in the cervical spine and was recommended to undergo MRI studies.

The record contained a peer review report dated 05/07/12.

The record included an MRI of the left shoulder dated 05/09/12 which noted mild tendinosis and tendinopathy involving the supraspinatus tendon distally near its insertion upon the humerus. There was a significant amount of osseous edema and soft tissue edema present surrounding the acromioclavicular joint suggestive of a recent acromioclavicular injury and mild acromioclavicular osteoarthritis.

When seen in follow up on 09/27/12, the claimant had continued complaints of shoulder pain and reported crepitus and popping on physical examination and there was a positive impingement sign, positive cross arm adduction tests were noted, and crepitations were noted. The claimant was able to elevate to 150 degrees and external rotation was to 40. Abduction strength was noted to be weak and lift off test was negative and she subsequently underwent a local corticosteroid injection.

The claimant was seen in follow up on 10/11/12 and at that time it was noted that the subacromial injection provided only temporary relief. She continued to have difficulty with overhead activity. It was reported that the claimant received extensive home exercise and physical therapy. The claimant was subsequently recommended to undergo surgical intervention and the initial review was performed on 10/25/12 who non-certified the request noting that the request included a proposed rotator cuff repair, however, and there were no imaging findings to support this diagnosis. He noted that the patient may warrant operative consideration, but at present the request was not authorized as submitted.

The appeal request was reviewed. noted that the previous non-certification was supported. He noted that there were no signs of cervical radiculopathy. Based on the MRI study, there were no full thickness rotator cuff tears to support the requested procedure and he noted that distal clavicle excision was being recommended and it did not appear that lower levels of care had been exhausted. He noted that there had been a corticosteroid injection in the subacromial space, but no specific injection into the acromioclavicular joint.

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

The request for left shoulder arthroscopy, subacromial decompression, distal clavicle excision, and rotator cuff repair is not supported by the submitted clinical information and the prior utilization review determinations are upheld. The submitted clinical records indicate that the claimant has evidence or the claimant sustained a work place injury and subsequently has had chronic pain in the left shoulder. She has been treated with oral medications and physical therapy. She continues to have significant levels of pain. She has received conservative treatment consisting of physical therapy and a subacromial injection. Records indicate that despite this, the claimant continues to have pain and the record does not establish that the claimant has truly exhausted all conservative measures. Further, the imaging studies do not support the medical necessity for the performance of a rotator cuff repair. There is no indication that the claimant has undergone acromioclavicular joint injections. Based upon the data that is provided, the claimant would not meet criteria per the Official Disability Guidelines for the requested procedures and therefore medical necessity was not established.

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)