Prime 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/17/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
outpatient right shoulder evaluation under anesthesia (EUA), diagnostic arthroscopy with debridement, subacromial decompression (SAD), Mumford repair and rotator cuff repair (RCR)

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:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Official Disability Guidelines
Notice of utilization review findings 12/22/11
Notice of utilization review findings 12/29/11
Employer's report of injury xx/xx/xx
X-rays right shoulder xx/xx/xx
MRI right shoulder 10/24/11
Family Medicine office / clinic note Dr. 09/15/11-11/22/11
Physical therapy progress/treatment notes 10/20/11-12/13/1
General orthopedic clinic note Dr. 12/16/11

PATIENT CLINICAL HISTORY SUMMARY
The claimant is a female whose date of injury isxx/xx/xx. She works at in, and she was pushed onto her shoulders by a resident causing pain to right shoulder. She has been treated with physical therapy x 13 sessions, which improved her right shoulder pain, but she is still having pain. MRI of the right shoulder performed 10/24/11 revealed type II acromion and some spurring of AC joint causing impingement; changes of tendinosis involving distal aspect of rotator cuff tendon with no full thickness tear seen. There is bone bruising and subchondral cystic changes of greater tuberosity with fluid signal in subscapularis tendon and attachment site of biceps tendon suspicious for tendinosis. There is no full thickness tear noted. Physical examination performed on 12/16/11 revealed the claimant to be 5'5" tall and weighs 167 lbs. Right upper extremity examination revealed pain with palpation of AC Joint as well as anterior acromion. There is pain with apprehension sign located in anterior aspect of shoulder. She has pain with cross arm test. She has full functional range of motion of right shoulder. She has pain with jogs (Jobe's?) and drop arm. The claimant was

recommended to undergo right shoulder arthroscopy.

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

This woman was injured on xx/xx/xx. She has had 13 sessions of physical therapy with improvement noted, but continued to experience right shoulder pain. Right shoulder MRI revealed degenerative changes including tendinosis of rotator cuff tendon without full thickness tear, with type III acromion and spurring of AC joint causing impingement. On examination the claimant had full functional range of motion of right shoulder.

She had pain with cross arm and pain with apprehension sign. There is pain to palpation of AC joint as well as anterior acromion. Per ODG guidelines, there should be at least 3-6 months of conservative treatment prior to consideration of surgical intervention. 3 months of conservative treatment is adequate if treatment has been continuous and 6 months if intermittent. It is noted on previous reviews that the claimant had received only two months of conservative treatment at time of request for surgical intervention. It was further noted there was no evidence of painful arc of motion 90-130 degrees, night pain, or evidence of temporary relief with diagnostic anesthetic injection. Therefore, the reviewer finds medical necessity has not been established for outpatient right shoulder evaluation under anesthesia (EUA), diagnostic arthroscopy with debridement, subacromial decompression (SAD), Mumford repair and rotator cuff repair (RCR).

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)