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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jul/11/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left first rib resection

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

M.D., Board Certified General 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. The reviewer finds the requested Left first rib resection to be medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Request for IRO 06/21/12

Utilization review determination dated 05/02/12

Utilization review determination dated 05/17/12

Radiographic report dated 11/18/09

Radiographic report dated 11/25/09

Clinical records Dr. 01/13/10-06/12/12

Operative report 09/13/10

Clinical records Dr.

Clinic note Dr. 12/22/10

Clinic note Dr. 02/01/11

Designated doctor's evaluation 04/29/11

MRI thoracic spine 05/02/11

Independent medical examination dated 07/14/11

Clinical records Dr. dated 03/28/12 and 04/26/12

Operative report 04/20/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured on xx/xx/xx. On the date of injury she was driving a minivan, which was struck from behind. She reported jamming her outstretched arm into steering wheel pushing her shoulder back. She had immediate pain in left shoulder.

Radiographs of left shoulder on 11/19/09 were reported as normal. MRI of left shoulder, which was performed on xx/xx/xx noted small focus of high grade tendinosis without tendon

retraction in distal supraspinatus tendon and evidence of mild bursitis.

Records indicate the claimant came under the care of Dr. on 01/13/10. She has complaints of ongoing left shoulder cervical spine pain with numbness and paresthesias in the left hand in C8 distribution. She is noted to have undergone physical therapy with minimal benefit. Records indicate the claimant received conservative treatment, which included oral medications, injections, and was recommended to undergo cervical MRI. Records indicate the claimant was ultimately referred to Dr.. On 05/26/10 she was referred for EMG/NCV study. This study noted no abnormalities. There was no evidence of left brachioplexopathy, no ulnar neuropathy or median neuropathy and no evidence of cervical radiculopathy. Records indicate the claimant underwent surgical intervention on 09/13/10. At this time she underwent left shoulder arthroscopy with supraspinatus debridement, subacromial decompression and bursectomy with distal clavicle excision. Postoperatively the claimant was referred for physical therapy. She is noted to be improved in terms of shoulder range of motion but continued to have pain in neck that radiates into left arm in C8 distribution. The claimant was later referred to Dr. who recommended additional studies to isolate the pain generator. Records indicate the claimant had no substantive benefit from conservative treatment. On 05/02/11 she was referred for MRI of thoracic spine. This study noted mild spondylosis at T11-12 and T12-L1 with mild acquired stenosis due to small central disc protrusion.

Records indicate that the claimant was largely treated with oral medication and physiotherapy she is noted to have undergone a vascular work up that was negative for a thoracic outlet syndrome.

On 03/28/12 the claimant was seen by Dr.. The claimant reports left arm numbness, swelling, and discoloration for a period of one year. On physical examination she is well developed, well nourished, and in no acute distress. She is noted to have a positive Adson's, AER and EAST test for bilateral thoracic outlet syndrome. She was referred for vascular studies. Angiogram of the left axillary artery was 0% at rest and 50% narrowing with the arm elevated with similar findings in the right axillary artery; angiography of the right internal jugular vein revealed 70% stenosis and 70% narrowing with collateral. These were balloon dilated pre and post treatment stenosis was reported to be 70%. Catheterization of the right subclavian vein revealed 50% stenosis and 95% narrowing with the arm elevated. The right axillary vein was catheterized angiogram was 0%. A balloon dilation of the right subclavian was performed pre treatment stenosis was 50% post treatment stenosis was 20%, there were findings of 90% stenosis of the left internal jugular vein; 90% narrowing with collaterals. This was catheterized angiography of the left axillary vein was 0% at rest 50% with the arm elevated. Pre treatment stenosis of the left internal jugular vein was 80% post treatment was 80% or pre treatment was 90% and post treatment was 80%. The claimant was seen in follow-up by Dr. on 04/26/12 a subsequent request was placed for surgical intervention.

The initial review was performed on 05/02/12, the reviewer non-certified the request noting that over 85% of patients with acute thoracic outlet syndrome with compression symptoms will respond to a conservative program including exercise. He notes that a confirmatory response to EMG guided scalene block and/or other confirmatory electrophysiologic testing is advisable before considering surgery. He further notes that diagnosis and consideration for surgery requires both subjective complaints as well as specific physical findings each dependent on whether the thoracic outlet syndrome is neurogenic or a vascular type. The reviewer notes that no vascular studies were available nor were the electrodiagnostic studies. Therefore, the clinical information was insufficient to diagnose or consider surgery for thoracic outlet syndrome and first rib resection was not medically necessary.

The appeal request was reviewed on 05/17/12. The reviewer notes that the clinical records did not provide any data regarding mechanism of injury diagnostic studies or provider information regarding conservative treatment to date. A peer to peer was conducted with Dr. on 05/17/12. Dr. indicated he would forward the medical records for review. The records were provided and do document the patient having classic findings of thoracic outlet compression syndrome but the records' faxed by Dr. did not contain sufficient information of

conservative treatment which Official Disability Guidelines requires and therefore there was a recommendation for non-certification of the requested first rib resection.

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

The submitted clinical records indicate that the claimant does have classic findings consistent with a diagnosis of thoracic outlet syndrome. The request was denied on appeal due only to lack of documentation with regard to conservative treatment. A complete clinical record was submitted with the IRO request. These records clearly document that this claimant has undergone extensive conservative treatment without benefit. Based upon the submitted clinical data, the reviewer finds the guidelines have been followed and the requested Left first rib resection is medically necessary. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be overturned.

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)