

Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 03/02/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left arthroscopic rotator cuff repair

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., F.A.C.S., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering shoulder problems

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
727.61	29826		Prospective				10/01/10	645C19409	Upheld

INFORMATION PROVIDED FOR REVIEW:

1. Certification of independence of the reviewer and TDI case assignment forms
2. case assignment
3. Letters of denial, 02/24/12 and 12/30/11 including criteria used in the denial
4. Record review, undated
5. Treating doctor's correspondence and office visits, multiple injuries, 01/12/11 through 12/30/11
6. Radiology report of MRI scan, left shoulder 12/09/11
7. History and physical examination, 01/03/11

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The claimant is a male suffering left shoulder pain. He has a date of injury given as xx/xx/xx related to microtrauma of repetitive activity hanging chickens. He suffered injury to his left hand and underwent a trigger finger release of the left long finger. He has had repeated episodes of left shoulder pain. He has had diminished range of motion and painful range of motion. An MRI scan performed 12/09/11 revealed a ninety percent partial thickness rotator cuff tear with a superior labral tear from anterior to posterior (SLAP) lesion of the labrum. He underwent a subacromial injection on 12/30/11 with dramatic symptomatic relief and immediate improvement in range of motion from 50 degrees of abduction to 150 degrees of abduction. The current request is for pre-authorization of arthroscopic surgery of the left shoulder to include rotator cuff repair. The request was denied. It was reconsidered and denied.

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

The claimant has undergone two documented subacromial injections with dramatic relief of symptoms, the first being in January of 2011 and the second being 12/30/11. There is no clear documentation of organized physical therapy and no documentation of regular medication treatment utilizing non-steroidal anti-inflammatory medications or similar medications. The non-operative treatment of this claimant's left shoulder pain is not well documented. The prior denials were appropriate and should be upheld.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

- ACOEM-American 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)