

SENT VIA EMAIL OR FAX ON
Feb/27/2012

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Feb/23/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Right Shoulder Scope AC Joint Resection, SAD, RTC Repair, Possible Labral Repair

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines
Request for IRO dated 02/07/12
Utilization review determination dated 02/06/12
Utilization review determination dated 01/12/12
Clinical records Dr. dated 12/20/11 and 01/05/12
MRI right shoulder 10/18/11
Duplicate records

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is reported to have sustained work related injuries on xx/xx/xx. The mechanism of injury is not described. The claimant was seen by Dr. on 12/20/11. He is reported to have previously had MRI and be scheduled for therapy through Administration. However, this never occurred because it was determined this happened at work and would be under worker's compensation. He is an insulin dependent diabetic. It was reported he has weakness and numbness and tingling in right upper extremity grip. He reported pain,

numbness and tingling into thenar eminences of right hand. He has significant pain with any attempts at external rotation. He is reported to have positive Neer and Hawkins sign of right shoulder. He had pain over anterolateral acromion, the AC joint with compression. MRI was reviewed and it was reported he has fairly significant labral tear at anterior superior labrum and adjacent paralabral cyst. The claimant was recommended to undergo EMG/NCV due to reported sensory deficits. The record includes MRI dated 10/19/11. This study shows superior labral tear with adjacent paralabral cyst dissecting posterior medially above bony glenoid extending into suprascapular notch. There is biceps tendinopathy without avulsion or dislocation. There is associated straining of distal subscapularis tendon without full thickness tear or retraction. There is tendinosis of the distal supraspinatus and infraspinatus tendons. There is tiny glenohumeral effusion extending into biceps tendon sheath. The claimant was seen in follow-up by Dr. McKenna on 01/05/12. He is reported to be status post EMG/NCV study. This was reported to be normal. He subsequently is recommended to undergo surgical intervention.

The initial review was performed on 01/12/12 by Dr. Dr. non-certified the request noting there is no documentation of recent comprehensive clinical evaluation, and there is no documentation with regard to failure of conservative treatment. As such, he non-certified the request.

An appeal request was reviewed by Dr. on 02/06/12. Dr. non-certified the appeal request noting that the request is not reasonable or medically necessary. He notes the guidelines for the procedure includes 3 months of conservative treatment and documentation of painful arc of motion, nocturnal pain, positive impingement signs, temporary relief with anesthetic injection. He notes the records provided fail to demonstrate 3 consecutive months of conservative treatment. He notes no evidence of full thickness rotator cuff tear. There have been no diagnostic injections, and there is no data to suggest the claimant had physical therapy. As such, he non-certified the request.

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

The request for right shoulder scope, AC joint resection, subacromial decompression, rotator cuff repair, possible labral repair, is not supported as medically necessary, and previous utilization review determinations are upheld. The submitted clinical records indicate the claimant sustained some form of shoulder injury. He is reported to have undergone conservative treatment which appears to have largely consisted of anti-inflammatory medications and time. The clinic notes do not indicate the claimant has undergone an appropriate course of conservative treatment. There is no indication of physical therapy. The record does not contain any data to suggest the claimant underwent intraarticular corticosteroid injections. There is no indication the claimant has undergone extended period of activity modification as recommended in the guidelines. In absence of more detailed clinical information, the request cannot be certified as medically necessary, and the prior determinations are upheld.

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

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

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES