

SENT VIA EMAIL OR FAX ON
May/12/2012

P-IRO Inc.

An Independent Review Organization
1301 E. Debbie Ln. Ste. 102 #203
Mansfield, TX 76063
Phone: (817) 405-0878
Fax: (214) 276-1787
Email: resolutions.manager@p-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
May/11/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
OP left clavicle hardware removal

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified Orthopedic Surgeon

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 04/30/12
Utilization review determination 04/10/12
Utilization review determination 04/26/12
Operative report 12/19/11
Clinical note Dr. 12/06/11-04/03/12

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is reported to have sustained a fracture to the left clavicle as a result of a fall on xx/xx/xx. The claimant was seen by Dr. on xx/xx/xx. He is noted to have had a fall from four feet from a trailer landing on his shoulder that is found to have a middle one third clavicle fracture. The claimant was subsequently taken to surgery on 12/19/11 at which time he underwent ORIF of the left clavicle fracture with intramedullary nail.

The record indicates the claimant had no significant postoperative complications. Radiographs performed on 01/03/12 note evidence of healing. He is recommended to

reduce activity level. He subsequently was recommended to be immobilized in sling. The claimant was seen in follow-up on 04/03/12 and noted to have full range of motion of left upper extremity. He is reported to have pain and problems with retained hardware that he wants to have taken out. Radiographs show excellent position and alignment of rods and well healed fracture. He has some prominence posteriorly of nail now that fracture is healed.

The initial review was performed on 04/10/12 by Dr.. Dr. non-certified the request noting there was no objective documentation that ramifications of hardware removal were discussed with the patient. There is no evidence of implant breakage or loosening on latest unofficial imaging study. There was no documentation regarding failure of postoperative conservative treatment.

The subsequent appeal request was reviewed on 04/26/12 by Dr.. Dr. non-certified the request noting there were no recent imaging studies submitted for review. There was no evidence of hardware migration. There was no documentation of failure to respond to conservative treatment, and 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 outpatient left clavicle hardware removal is not supported by the submitted clinical information. The available medical record indicates the claimant sustained fracture of left clavicle which was treated with intramedullary nailing. Records indicate the fracture has subsequently gone on to heal and claimant has full range of motion. The record does not adequately quantify the claimant's pain levels or fully explore or evaluate to establish the claimant's shoulder dysfunction is result of symptomatic hardware. There is no indication from provided imaging studies that the hardware has migrated or failed. The records do not provide adequate information to suggest retained IM nail is causing significant levels of pain or functional loss. Therefore, the prior utilization review determinations were appropriate and upheld.

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)