

IRO Express Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

Signed electronically on: Oct/29/2012

DATE NOTICE SENT TO ALL PARTIES:

Oct/30/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

OP right acromioclavicular joint reconstruction with allograft

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

Board Certified Orthopedic Surgeon (Joint)

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Cover sheet and working documents

MRI right shoulder dated 05/03/12

Patient referral dated 05/22/12

Orthopedic specialist consultation

Encounter notes 06/15/12-07/10/12

Utilization review determination dated 07/23/12

Utilization review determination dated 10/11/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male. The records indicate that he was throwing trash into a dumpster while standing on the back of a flatbed truck. He slipped and fell forward, hitting the anterior shoulder on the dumpster. He then tried to catch himself with his right arm by hanging onto the dumpster, and slipped off the truck. MRI of the right shoulder dated 05/03/12 revealed posterior superior labral tears; acromioclavicular joint osteoarthritis with attenuation/resorption of the distal articular margin of the clavicle which may be post-traumatic or post-inflammatory in etiology; no rotator cuff tear. Records indicate that the claimant was treated conservatively by being placed in a sling and prescribed medications. Records indicate that the claimant sustained a previous injury 18 months prior to this injury and was treated for a grade III AC joint separation. This was treated non-surgically and was non-work-related. The claimant reports he had fully recovered from the previous injury and was back to work, full duty, with no issues. He currently complains of right shoulder pain. The claimant was seen in follow-up on 07/10/12, now 4 weeks out from a right AC joint separation. He reportedly has been doing therapy with improvement in range of motion but no improvement in level of pain. The claimant reports he has had an increase in numbness and tingling. Physical examination reported right shoulder AC problem that is exaggerated and scapular winging. Right shoulder range of motion testing revealed abduction of 130 degrees, forward flexion 160 degrees, and internal rotation T6 versus left shoulder 150, 170, and T4. Hawkins's and Neer's tests were positive. O'Brien's test was negative. Speed's test was negative. Empty can test was negative. Subscapularis strength test was normal. There was a positive cross arm abduction test. The claimant was recommended to undergo left AC joint reconstruction.

A request for outpatient right AC joint reconstruction with allograft was reviewed on 07/23/12 and the request was non-certified as medically necessary. The reviewer noted that the submitted clinical records indicate that the claimant has a chronic history of ACJ separation that had acquiesced. The record does not provide detailed information regarding the prior injury to include imaging studies to establish the extent of injury. The records do not fully establish that the claimant has failed appropriate conservative management. As such, the request cannot be supported as medically necessary.

A reconsideration/appeal request was reviewed on 10/11/12 and the request again was non-certified as medically necessary. The reviewer noted that the request was previously denied due to the claimant not having documentation of previously undergoing a course of conservative treatment in addition to not having imaging reports of the previous injury. Documentation submitted noted the claimant to have a chief complaint of right shoulder pain. Official Disability Guidelines indicate certain criteria must be met before an indication for surgery. The claimant was noted to have positive impingement signs and pain on palpation of the right shoulder; however, the documentation did not note the current number of physical therapy sessions the claimant has had to date and how long the claimant has been attending physical therapy. Current guidelines recommend 3-6 months of conservative care with treatment directed toward gaining full range of motion. In addition, the claimant should have temporary relief of pain with an anesthetic injection (a.k.a. diagnostic injection test). Without further documentation to note the claimant's conservative care, necessity of the surgical procedure cannot be medically substantiated at this time.

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

Based on the clinical data provided, the request for OP right AC joint reconstruction with allograft is not supported as medically necessary. The claimant sustained an injury on 04/30/12. He initially was treated with a sling and medications. He has a previous history of a non-work-related injury to the same shoulder with a grade III AC joint separation approximately 18 months earlier for which he was treated non-surgically. The claimant reported he has been doing therapy, but no progress notes were submitted for review documenting the total number of therapy visits completed to date. Per Official Disability Guidelines, there should be at least 3-6 months of conservative treatment including physical therapy/exercise, anti-inflammatory medications, and other conservative measure prior to consideration of surgical intervention. There also is no indication that the claimant has had a

diagnostic injection of the right shoulder. Given the current clinical data, medically necessary is not established for the proposed surgical procedure. The request does not meet ODG criteria, and previous denials are 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)