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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Nov/19/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient left shoulder rotator cuff repair (RCR) with resection of left distal clavicle and rental of cold therapy unit for seven (7) days.

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
Request for IRO 10/31/12
Receipt of request for IRO 11/05/12
Utilization review determination 10/03/12
Utilization review determination 10/18/12
MRI left shoulder 04/02/11
Clinical records 09/14/11-10/08/12
MRI left shoulder 10/06/11
Utilization review determination 06/21/12
Physical therapy treatment records

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who is reported to have a date of injury of xx/xx/xx and the mechanism of injury is not described.

On 04/02/11, the claimant was referred for imaging studies. At this time, she underwent MRI of the left shoulder which identified supraspinatus and infraspinatus tendinosis without definite tears. Prominent mucoid degeneration of the superior labrum with no definitive tears. Abnormal signal and thickening of the inferior glenohumeral ligament. There were mild hypertrophic and degenerative changes of the acromioclavicular joint.

The claimant was seen in follow up 09/14/11 and she was noted to have undergone physical therapy and been treated with anti-inflammatories. She continues to have significant levels of pain on exam. She has positive Hawkins, Neer, full can and Jobe's tests. Her strength was graded as 3/5.

The claimant was referred for MR arthrogram which was performed on 10/06/11 and this study notes persistent supraspinatus tendinosis with a punctate subarticular partial thickness tear. No full thickness tears were identified. There was persistent infraspinatus tendinosis without defying tears. There was mild mucoid degeneration of the superior labrum without evidence of tears. There were no abnormalities to the inferior glenohumeral ligament. There were persistent mild degenerative changes of the acromioclavicular joint with lateral downward sloping acromion.

On 10/19/11, the claimant was seen in follow up and it was noted that the recent MRI showed less than a 50% tear with some hypertrophy on the acromioclavicular joint which may require additional conservative management and opines that the claimant is not a candidate for immediate surgery.

On 06/06/12, the claimant was seen in follow up and she was noted to have continued pain in the shoulder. There is pain with abduction and external rotation. She has increasing pain when she lifted anything over 10 pounds and there was tenderness over the acromioclavicular joint. She was noted to have undergone physical therapy and injections which only provided a few weeks' worth of relief. She subsequently was recommended to undergo a subacromial decompression for her impingement syndrome.

The record includes a utilization review determination dated 06/21/12 in which the surgical procedure was approved by the reviewing physician.

The claimant was seen in follow up on 10/08/12. The records indicate that the claimant continued to have significant limitations in range of motion and she was noted to have positive Hawkins, Neer, full can and Job's tests. She has 90 degrees of active abduction and about 100 degrees of forward flexion. She was noted to have undergone six weeks of therapy and cortisone injections. She was unable to have her previous surgery in the approval window as she was required to travel by her employer.

The initial review was performed on 10/03/12. non-certified the request opining that the supplied information did not provide sufficient data regarding the current clinical situation.

The appeal request was reviewed on 10/18/12. He non-certified the appeal request noting that the description of the MRI in May and October indicates a progression of tendinosis to a partial thickness tear over that period. He noted that opined that the claimant may have a full thickness tear which tears, although he did not explain why he thinks so. The claimant had pain with provocation for impingement. She was reported to have decreased active range of motion and pain despite conservative care.

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

The request for outpatient left shoulder rotator cuff repair with resection of the left distal clavicle and rental of cold therapy unit for seven days is recommended as medically necessary and the prior utilization review determinations are overturned. The submitted clinical records indicate that the claimant sustained an injury to the left shoulder as the result of work related activity. She has undergone an extensive course of conservative treatment which has consisted of oral medications, physical therapy, and corticosteroid injections. The records indicate that the claimant was previously approved for surgical intervention. However, she was unable to undergo surgery during the approved window. Her physical examination remains unchanged. She continues to have significant functional limitations with evidence of pathology on imaging studies. There is clear correlation between the claimant's imaging studies and objective findings on physical examination. There is ample documentation to establish that the claimant has previously failed appropriate conservative management.

Further, the claimant has been previously approved for surgical intervention by another reviewer. Based upon the totality of the clinical information, the request is medically necessary and the prior determinations are 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)