

True Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Sep/24/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Shoulder Orthosis

1 Surgical Assistant;

1 Right Shoulder Diagnostic Arthroscopy with Subacromial Decompression, Superior Lateral Anterior Posterior Repair, Cyst Decompression and Extensive Debridement

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

Board Certified Anesthesiology

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
Notification of utilization review determination 08/22/12
Utilization review 08/22/12
Notification of utilization review determination 08/28/12
Utilization review 08/27/12
Pre-authorization request 07/27/12
Reconsideration/appeal request undated
Initial orthopedic consultation note 07/23/12
MRI cervical spine 05/24/12
MRI right shoulder 07/11/12
Office note 05/14/12
Patient information form 05/14/12
Progress note 07/09/12
Physical therapy initial evaluation 05/15/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male whose date of injury is xx/xx/xx. The claimant stated he injured his

right back/neck. He reported immediate sharp pain in the shoulder region. There was concern of a possible cervical disc, and MRI of the cervical spine was performed on 05/24/12 which revealed a modest C5-6 protrusion minimally impinging upon the cord and narrowing the canal, with minimal neural foraminal narrowing at this level. MRI of the right shoulder performed 07/11/12 revealed a 2cm paralabral cyst at the mid inferior/anteroinferior labrum, indicating an underlying labral tear; intact superior labrum and biceps tendon labral anchor; moderate subscapularis tendinopathy with some mild supraspinatus tendinopathy; type 2 acromion with minimal bursitis. Physical examination on 07/23/12 showed evidence of anterior and deep shoulder pain with external rotation into overhead elevation as well as a markedly positive Speed and O'Brien test. Hawkins was only mild with a little discomfort more than weakness. There was no instability. There was fairly good parascapular muscle tone. The AC joint was non-tender. The proximal biceps tendon sheath was very tender. There was no distal swelling. It was noted that the claimant is now two months out and despite conservative measures he has not had any substantial improvement and was recommended to proceed with diagnostic shoulder arthroscopy, subacromial decompression with SLAP/labral repair, cyst decompression and extensive debridement.

A pre-authorization request for surgical assistant, shoulder orthosis, and right shoulder diagnostic arthroscopy with subacromial decompression, superior labral anterior posterior repair, cyst decompression and extensive debridement was reviewed on 08/22/12, and the request was non-certified as medically necessary. It was noted that the claimant sustained an injury when he reached for a product in bread truck and felt sharp pain in his neck. He was noted to have sustained cervical strain/radiculopathy and right shoulder strain. He was treated conservatively with ice/hot packs and nominal therapy. He continued working modified duty. He was certified with six physical therapy visits of the cervical spine. He has had medication regimen and activity restrictions. MRI of the right shoulder showed a 2cm paralabral cyst at the mid inferior/anteroinferior labrum indicating an underlying labral tear; intact superior labrum and biceps tendon labral anchor; moderate subscapularis tendinopathy with some mild supraspinatus tendinopathy; type 2 acromion with minimal bursitis. It was noted that the claimant complains of right shoulder pain which is deep and runs from anterior to posterior. Pain remains very sharp and stabbing, and over time the claimant developed pain that radiates towards his neck and dull pain radiating down laterally across the deltoid. Reviewer noted that the claimant participated in physical therapy session without substantial improvement; however there was lack of information regarding lack of improvement in activities of daily living, range of motion and pain scores including the number of completed sessions, modalities used and patient compliance including that of the previously certified session for the cervical spine. There also was no evidence in the medical report submitted of the claimant's failure to respond to other less invasive treatment modalities such as activity modification, corticosteroid injections and bracing. It was noted that the post-operative course includes subjective complaints and physical examination during follow up is essential to assess the need for shoulder orthosis and medical necessity has not been established. Subsequently request for surgical assistant is non-certified.

A reconsideration/appeal review of the previous non-certification was performed on 08/28/12, and request again was non-certified as medically necessary. It was noted that the clinical notes mention the claimant's previous involvement with conservative therapy; however, it appears the claimant has only attended one physical therapy session. Additionally there was a lack of information regarding the claimant's specific complaints with active arc of motion from 90-130 degrees as well as complaints of pain at night. Given the lack of information regarding the claimant's completion of three to six months of conservative treatments and taking into account the lack of information regarding the claimant's significant clinical findings the request does not meet guideline recommendations and the documentation submitted for review does not support the request as medically necessary.

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

The request for one shoulder orthosis; one surgical assistant; one right shoulder diagnostic arthroscopy with subacromial decompression, superior labral anterior posterior repair, cyst decompression and extensive debridement is not supported as medically necessary.

Claimant is noted to have sustained an injury when he was reaching for product in a bread truck and injured his neck and right shoulder. MRI of the right shoulder revealed a paralabral cyst, with intact superior labrum and biceps tendon labral anchor. Moderate subscapularis tendinopathy was noted with some mild supraspinatus tendinopathy. A type 2 acromion was noted with minimal bursitis. The claimant was referred for physical therapy, with documentation presented included only initial physical therapy evaluation on 05/15/12. Physical examination performed during initial orthopedic consultation revealed positive Speed and O'Brien test with mildly positive Hawkins, but no instability. No range of motion measurements were provided indicating painful arc of motion 90-130 degrees. There also was no indication of night pain. It does not appear that the claimant underwent anesthetic/diagnostic injection test with evidence of temporary relief of pain. Per Official Disability Guidelines, there should be at least three to six months of conservative treatment prior to consideration of surgical intervention. Given the current clinical data, the request does not meet Official Disability Guidelines criteria and medical necessity is not established. Consequently 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)