

Notice of Independent Review

REVIEWER'S REPORT

DATE NOTICE SENT TO ALL PARTIES: 03/19

IRO CASE #:

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

Texas-licensed M.D., board certified in Orthopedic Surgery

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient right shoulder under anesthesia (EUA), arthroscopy with debridement, subacromial decompression (SAD), Mumford, rotator cuff, superior labrum anterior-posterior (SLAP) repair.

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)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
718.01	23120		Prosp				Xx/xx/xx	Pending	Overturn

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. TDI case assignment.
2. Letters of denial 02/14/13 & 03/04/13, including criteria used in the denial.
3. Radiology reports 08/23/12 and 09/07/12.
4. Preauthorization request 02/08/13.
5. Treating doctors assessments and follow up 10/22/12 & 12/17/12.
6. letter dated 02/18/13
7. Clinical notes 02/20/13 & 10/22/12.
8. Echocardiogram 02/18/13. X-ray right shoulder 08/22/12
9. PT evaluation 10/31/12. PT documentation and order summary 10/22/12.
10. Medication profile 06/15/12.

PATIENT CLINICAL HISTORY (SUMMARY):

The injured employee is a male who suffered a straining injury to his right shoulder when attempting to manipulate a heavy wrench while installing duct work. The date of injury was xx/xx/xx. He has had persistent pain in the right shoulder in spite of treatment utilizing activity modifications, oral medication, and Voltaren Gel application and physical therapy. The patient has had physical therapy with maintenance of a functional range of motion. However, he continues to suffer pain in the extremes of abduction, forward flexion, and rotation. The patient has extensive co-morbidities including obesity, cardiovascular disease, hypertension, hypothyroidism, and diabetes mellitus. He takes extensive medications for these co-morbidities. The current request is for examination under anesthesia, debridement including Mumford procedure, and rotator cuff as well as labral pathology repair. The patient underwent an MRI scan which identified tearing of the anterior fibers of the supraspinatus muscle as well as further degeneration of the rotator cuff. He also has superior and posterior labral lesions. Mild degenerative changes are present in the acromioclavicular joint with osteophyte formation superiorly. It would appear that this patient's physical therapy has maintained a functional range of motion while symptoms of persistent pain which interfere with the activities of daily living including interference with sleep at night have persisted. The requested preauthorization for surgical procedure including examination under anesthesia, subacromial decompression, rotator cuff and labral repair with Mumford procedure was requested and denied.

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

The examination of this patient reveals functional range of motion with persistent pain. MRI scan has revealed pathology which is amenable to the surgical procedure requested for preauthorization. The injured employee has an extensive co-morbidity including obesity, hypertension, hypothyroidism, and diabetes mellitus. In spite of appropriate non-operative management, the patient is still symptomatic with pain. He has activity restrictions and interference with the activities of daily living including interference with ability to obtain rest at night. The request for the treatment/services in dispute as stated above should be approved.

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

- ACOEM-American 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 judgment, clinical experience and expertise in accordance with accepted medical Standards
- Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Office 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)