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Notice of Independent Review Decision

Date notice sent to all parties: 7/29/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

LT shoulder EUA, dx arthroscopy w/ debridement, SAD, Mumford, RCR

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

Texas Licensed, 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. IRO Request
2. LHL009
3. 6/5/13 and 6/17/13 Denial letters with rationale
4. 7/19/13 Letter to IRO
5. 5/29/13 Preauthorization request
6. 5/28/13 Procedures to be scheduled form
7. 5/24/13 and 7/15/13 notes
8. 4/12/13 notes
9. 4/12/13 DX Shoulder Complete 2+ (Left) report
10. 1/17/13 MRI Shoulder without Contrast (Left)
11. 4/16/13 Physical Therapy evaluation/notes
12. 4/12/13 Physical Therapy orders
13. Worker's Compensation Information Form
14. 5/29/13 Plan of Care
15. Therapy and Exercise Log
16. 5/7/13-5/30/13 Physical Therapy Weekly Progress Notes
17. Title 28 Insurance, Ch. 12 Independent Review Organizations; Pg. 142-150
18. 7/17/13 Reconsideration Preauthorization Request

PATIENT CLINICAL HISTORY [SUMMARY]:

Has a history of persistent pain and reported instability at the level of his left shoulder. The shoulder was injured while working on xx/xx/xx. The records reveal that he has had a history of "positive drop-arm" and overall feeling of instability despite treatment reportedly with a full course of physical therapy. The claimant has been documented on examination to have as noted for example on 05/24/2013 "Pain with anterior apprehension sign. Positive relocation test. Positive O'Brien's test. There is 1+ anterior glenohumeral laxity to stress..1+ inferior sulcus sign.." The electrodiagnostics were not noted to reveal any radiculopathy or neuropathy and the MRI of the affected shoulder has been noted to be unremarkable. It should be noted that there is a strong past medical history of recurrent dislocation of the left shoulder again most recently associated with the workplace DOI of xx/xx/xx. The claimant has been noted to have undergone a course of restricted activities and at least "12 sessions of physical therapy." The MRI of the shoulder from 01/27/2013, which was without contrast, was noted to be essentially unremarkable. Denial letter has indicated the lack of provision of the actual therapy records and the lack of injection attempt of the shoulder diagnostically and/or therapeutically.

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

The claimant has had a reasonable full course of treatment for what appears to be a strong history of at least an aggravated recurrent dislocation of the left shoulder. The claimant has failed restricted activities and therapy along with medications. He has strongly positive objective findings despite the negative MRI (without contrast.)

In light of the strongly positive clinical history of workplace-associated dislocation, the strongly positive physical examination findings compatible with glenohumeral/shoulder subluxation-dislocation; the reportedly negative MRI must be considered far below any reliable level of conclusiveness. In fact, it therefore is 'at best' inconclusive and 'at worst' it is fully inconsistent with the established clinical facts in this case. The MRI findings clearly did not accurately reflect the clearly pathologic combination of labral tear, ligamentous and muscle laxity and/or loose intraarticular body that were imaging- obscured by other shoulder structures. The claimant at this time clearly has evidence of a persistently painful internal derangement of the shoulder including a highly plausible glenoid socket labral tear. The applicable ODG guidelines for treatment for a torn labrum, impingement syndrome and rotator cuff tear have been referenced and this individual has met those guidelines. Guidelines do support these requests due to the persistent and relatively severe clinical issue including subjective and objective findings. The strong history does correlate positively with the injury mechanism. The claimant has an indication for surgical intervention as reasonable and comprehensive non-operative treatment have been adequately documented to have been tried and failed.

Therefore, the request for a more thorough evaluation, i.e. an evaluation under anesthesia, a diagnostic arthroscopy with debridement of tissues for optimized visualization and/or treatment is reasonable and medically necessary at this time based on clinical guidelines. A subacromial decompression for visualization purposes and to decompress the positive impingement findings, with similar treatment of a debridement of distal clavicle in the form of a Mumford, and, rotator cuff repair if evident intra-articularly are reasonable and medically necessary if objective findings of the EUA and diagnostic arthroscopy support the necessity of these procedures. The claimant does have an indication for the requests and they are reasonable and medically necessary. The prior denials at this time are indicated to be overturned based on the applicable clinical guidelines both for the internal derangement/recurrent subluxation/dislocation/probable labral tear and also for impingement syndrome with associated rotator cuff pathology if proven by the above diagnostic arthroscopy.

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 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)**