

Independent Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Dec/27/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Resection of the Right Clavicular Head of the Shoulder

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

Board Certified General Surgery

Fellowship: Orthopedic Hand and Upper Extremity Surgery

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

IRO referral documents

Preauthorization review 11/16/12

Preauthorization review 11/29/12

Preauthorization request 11/07/12

Office visit notes 10/30/12

CT sternum 10/04/12

MRI right shoulder 05/04/12

Office visit 10/02/12 and 10/09/12

Operative report right shoulder arthroscopy 07/02/12

MRI right sternoclavicular joint 05/16/12

Progress notes 06/06/12-10/10/12

Physical therapy progress reports 07/18/12-10/01/12

Progress notes 04/21/12-06/22/12

Preauthorization appeal request 11/21/12

Stress test 11/20/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male whose date of injury is xx/xx/xx. The claimant reported lumber slid off a truck and hit him on the left side of the face and head causing him to fall and landing on his

right shoulder onto a boulder. MRI of the right shoulder performed on 05/04/12 was reported as a suboptimal evaluation secondary to extensive patient motion artifact; suspect to partial tearing involving the anterior aspect of the distal supraspinatus tendon; no evidence for fracture, alignment abnormality or marrow edema; advanced arthropathy of the acromioclavicular joint. After failing conservative treatment including therapy and subacromial injection, the claimant underwent right shoulder arthroscopy with subacromial decompression, distal clavicle excision, arthroscopic rotator cuff repair, and open biceps tenodesis performed on 07/02/12. The claimant participated in postoperative physical therapy. He continued to complain of right shoulder pain. CT scan dated 10/04/12 revealed posterior dislocation of right clavicular head, seen on prior MRI from 05/16/12. The clavicular head abuts the anterior wall of the brachiocephalic artery. No fracture was seen. The claimant was diagnosed with sternoclavicular joint posterior subluxation.

A prospective request for resection of the right clavicular head of the shoulder was non-certified per review dated 11/16/12. The reviewer noted that the claimant was status post-surgical intervention with good range of motion. He had continued subjective complaints of pain. Imaging studies indicated subluxation of the clavicular head, but there was no clinical information regarding dynamic movement of the clavicular head. General opinions were that the procedure was risky with potential for iatrogenic injury. It was unclear if the potential benefits outweighed the clear risk of the procedure based on lack of sufficient clinical information it was not possible to determine the medical necessity.

An appeal request for resection of the right clavicular head of the shoulder was non-certified per review dated 11/29/12. It was noted that the claimant underwent right shoulder arthroscopy with subacromial decompression, distal clavicle excision, arthroscopic rotator cuff repair, and open biceps tenodesis on 07/02/12 and subsequently attended post-operative physical therapy. He responded positively to post-operative rehabilitation, but symptoms pertaining to the subluxed right clavicular head persisted. Right shoulder examination on 09/10/12 revealed good supraspinatus and internal/external rotation strength. Passive forward flexion was 160 degrees, external rotation was 90 degrees and internal rotation was 75 degrees. There was exquisite tenderness elicited over the right sternoclavicular joint. CT scan of the sternum dated 10/04/12 demonstrated posterior dislocation of the right clavicular head with the clavicular head abutting the anterior wall of the brachiocephalic artery, and no fracture noted. It was noted that updated documentation submitted for the appeal did not address the concerns expressed on initial non-certification. A specific rationale that clearly justified proceeding with the surgery despite the risks involved was not reported. Positive objective findings (other than pain) that may clinically warrant the requested surgery were not reported in the latest medical report. Information regarding the dynamic movement of the clavicular head was also still not provided. Based on these grounds, medical necessity of the request was non-substantiated and the previous non-certification was upheld.

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

The claimant was noted to have sustained an injury on xx/xx/xx, requiring right shoulder arthroscopy which was performed on 07/02/12. Despite post-operative therapy, the claimant continued to complain of right shoulder pain. Imaging studies revealed posterior dislocation of the right clavicular head with the clavicular head abutting the anterior wall of the brachiocephalic artery. However, as noted on previous reviews, there was no information indicating dynamic movement of the clavicular head. Previous reviews also noted that the proposed procedure is a very risky surgery with potential for iatrogenic injury. There was no response indicating that the potential benefit of surgery clearly justifies proceeding despite the risks involved. There were no positive objective findings other than pain that would warrant the requested surgery. Based on the clinical data provided for review, it is the opinion of this reviewer that medical necessity is not established for the proposed procedure.

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)