

Notice of Independent Review Decision

December 31, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Diagnostic Arthroscopy Right Shoulder to Evaluate both the Suprspinatus Tendon and the Biceps Tendon

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

The physician performing this review is Board Certified, American Board of Orthopedic Surgery. The physician has been in practice since 1998 and is licensed in Texas, Oklahoma, Minnesota and South Dakota.

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.

Upon independent review, I find the previous adverse determination should be overturned.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Records Received: 17 page fax 12/11/12 Texas Department of Insurance IRO request, 9 pages of documents received via fax on 12/13/12 URA response to disputed services including administrative and medical. Dates of documents range from xx/xx/xx (DOI) to 12/11/12.

PATIENT CLINICAL HISTORY [SUMMARY]:

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25 Highland Park Village #100-177 Dallas TX 75205

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Patient is a female with a reported work-related injury to her right shoulder. She has had conservative therapies, including activity modification, physical therapy, and anti-inflammatory medications. She continues to have pain and as a consequence has lost her previous job. MRI has indicated supraspinatus tendinosis. The treating doctor feels that based upon the patient's continued pain and physical examination findings, this perhaps is indicative of an occult tear and has suggested diagnostic arthroscopy.

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

The medical records available to review indicate the patient has pain with provocative testing of the supraspinatus and other rotator cuff structures. Additionally, there is tenderness over the bicipital groove consistent with biceps tendinopathy. The MRI shows substantial tendinopathy, which could be a sign of occult tear as the physician described. The patient appears to have had adequate physical therapy treatments without significant benefit.

Utilizing the ODG criteria below, this case appears to meet the criteria, in my opinion. Specifically, acute pain and functional limitation continue despite what would appear to be adequate conservative care.

ODG -TWC

ODG Treatment

Integrated Treatment/Disability Duration Guidelines

Shoulder (Acute & Chronic)

Diagnostic arthroscopy	Recommended as indicated below. Criteria for diagnostic arthroscopy (shoulder arthroscopy for diagnostic purposes): Most orthopedic surgeons can generally determine the diagnosis through examination and imaging studies alone. Diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Shoulder arthroscopy should be performed in the outpatient setting. If a rotator cuff tear is shown to be present following a diagnostic arthroscopy, follow the guidelines for either a full or partial thickness rotator cuff tear. (Washington, 2002) (de Jager, 2004) (Kaplan, 2004) For average hospital LOS if criteria are met, see Hospital length of stay (LOS).
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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)