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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jun/12/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: left shoulder removal of hardware

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O. Board Certified Orthopedic 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. It is the opinion of this reviewer that the request left shoulder removal of hardware is recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
CT scan of the left shoulder dated 05/11/12
Clinical notes dated 05/14/12 – 04/15/13
Previous utilization reviews dated 03/21/13 & 04/22/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who reported an injury regarding her left shoulder. The CT scan of the left shoulder dated 05/11/12 revealed a minimally displaced severely comminuted fracture involving the humeral head and neck. The clinical note dated 05/14/12 details the patient being recommended for an ORIF of the humeral head and neck fracture. The clinical note dated 05/30/12 details the patient having undergone an ORIF to the proximal humerus. The patient was noted to be utilizing an immobilizer sling. The patient was recommended to initiate physical therapy in approximately 2 weeks as part of the postoperative care. The clinical note dated 06/20/12 details the patient undergoing radiographic films which revealed the humerus to be in an acceptable alignment. An early callous formation was noted. The plates and screws were noted to be in acceptable alignment as well. No signs of loosening were noted. The clinical note dated 07/25/12 details the patient utilizing Hydrocodone for ongoing pain relief. The patient was noted to demonstrate a gradual improvement regarding her healing fracture. The clinical note dated 09/18/12 details the patient being recommended for formal physical therapy in order to regain range of motion and strength. The fracture was noted to be healing quite well. The clinical note dated 12/12/12 details the patient being recommended for hardware removal. The note does detail the patient having undergone physical therapy with an improvement regarding her motion. The clinical note dated 04/15/13 details the patient complaining of pain at the left shoulder. The note does detail the patient regressing regarding her pain level. The patient rated her pain as 6/10 at that time. Mild to moderate tenderness was noted over the implanted screws.

The previous utilization review dated 03/21/13 resulted in a denial for hardware removal secondary to a lack of information indicating the patient's complaints of pain at the implanted hardware site.

The previous utilization review dated 04/22/13 resulted in a denial for hardware removal secondary to a lack of information indicating hardware involvement regarding the patient's complaints of pain.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation submitted for review elaborates the patient complaining of ongoing left shoulder pain despite a previous surgical intervention. Hardware removal would be indicated provided the patient meets specific criteria to include significant complaints of pain at the previously implanted hardware site or the patient's hardware is noted to be broken. The most recent clinical note does detail the patient having specific complaints of tenderness at the previously implanted screws. Given the significant complaints of pain involving the left shoulder implanted screws, this request is reasonable. As such, it is the opinion of this reviewer that the request left shoulder removal of hardware is recommended as medically necessary.

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)