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Notice of Independent Review Decision

DATE OF REVIEW: 5/3/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of arthroscopy, shoulder, surgical; debridement, limited.

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

The reviewer is a Medical Doctor who is board certified in 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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of arthroscopy, shoulder, surgical; debridement, limited.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source):

Records reviewed:
LHL009 – 4/9/13

Denial Letters – 3/7/13, 4/18/13

Reconsideration Acknowledgement Letter – 4/16/13

Peer Review Reports – 3/6/13, 4/16/13

Pre-authorization Requests – 3/4/13, 3/15/13

Clinical Encounter Summaries – 2/6/13, 2/14/13, 2/25/13

Order Group Summaries – 2/13/13

Patient Case Note – 3/15/13

MRI Upper Extremity Joint w/o Contrast Right - 2/4/13

SOAP Notes – 2/4/13, 2/6/13

Office Note – 2/13/13, 3/14/13

Various DWC73's

Denial Letter – 3/18/13

Records reviewed from Madsen Orthopedics:

Cardiopulmonary Scoring Report – 3/7/13

Progressive Exercise Program – 3/7/13

Facesheet – undated

Office Note – 3/7/13

SOAP Notes – 1/4/13, 1/5/13, 1/7/13, 1/8/13, 1/17/13, 1/18/13, 1/21/13, 1/23/13,
1/24/13, 1/28/13, 2/11/13, 2/26/13, 2/28/13

Patient Symptom Rating Scale – 4/3/13

Records reviewed:

Office Notes – 1/9/13, 1/16/13, 1/30/13, 4/3/13, 4/24/13

New Patient Note – 1/3/13

Progress Note – 2/6/13, 2/14/13

Functional Capacity Evaluation – 2/12/13

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant was noted to have sustained a shoulder injury while lifting while working on xx/xx/xx. He has been noted to have persistent shoulder pain despite medications, injection, therapy and restricted activities. Objective findings include tenderness and painful restricted motion, along with a positive test for impingement and “drop-arm.” A 2/4/213 dated shoulder MRI has revealed AC joint hypertrophy and rotator cuff impingement/tendinosis. The Attending Physician treatment records included from prior to and after the 2/14/13 dated cortisone injection which helped for days only, as noted on 2/25/13. A recent note (dated

3/15/13) discussed a consideration for surgery. Therapy records noted 12 visits over a 6 week date range. Denial letters notes the lack of comprehensive and recent trial and failure of non-operative treatments over at least a 3 month period.

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

Although the claimant has had some non-operative treatments including medications, one injection and physical therapy (along with restricted activities); at least a three-month trial and failure of such comprehensive treatments has not been documented. Therefore, applicable clinical guideline criteria have not been fully met at this time. The requested procedure is not medically necessary.

ODG Shoulder Chapter:

ODG Indications for Surgery™ -- Acromioplasty:

Criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome (80% of these patients will get better without surgery.)

1. Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS
2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees. AND Pain at night. PLUS
3. Objective Clinical Findings: Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS
4. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of impingement.(Washington, 2002)

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)