

Notice of Independent Review Decision

February 13, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Request: Brachial Plexus Block. Axillary Block, Right Shoulder Arthro Distal Clavicle, Right Shoulder Rotator Cuff Repair

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 the physician finds that the previous adverse determination should be ~ Partially Overturned

PATIENT CLINICAL HISTORY [SUMMARY]:

is a male at the time of this dictation with right shoulder pain following a work injury of xx/xx/xx. has had ample physical therapy treatment with little improvement noted. He continues with pain with any and all use of the right shoulder. Imaging studies show small full-thickness supraspinatus tear, a partial subscapularis tear, along with a moderate tear of the posterior inferior labrum and tendinosis of the long head of the biceps. Physical examination shows impingement sign with motor weakness. Specifically mentioned is negative tenderness at the acromioclavicular joint on the right side.

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

This patient has physical examination and imaging studies consistent with rotator cuff tear and signs of impingement. He has also failed physical therapy treatment for an adequate period of time. As a consequence, ODG guidelines are met for rotator cuff repair and subacromial decompression. Additionally, ODG guidelines allow for regional anesthesia as recommended when used by experienced practitioners. However, the medical records indicate there is no tenderness over the acromioclavicular joint on the affected side. Additionally, there is no evidence for severe AC joint arthrosis and again, no evidence for tenderness at the AC joint with no description of severe arthrosis of the joint. As a consequence, ODG guidelines for partial claviclectomy have not been met.

Recommendation by the treating surgeon is for arthroscopic subacromial decompression with arthroscopic distal claviclectomy and evaluation of the rotator cuff along with the use of regional anesthesia, as described above. All procedures, with the exception of the distal claviclectomy, meet *ODG* guidelines.

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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)