C-IRO Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Nov/21/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Left Shoulder Scope, AC Joint Resection, Subacromial Decompression RTC Repair

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgery

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] 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 <u>each</u> health care service in dispute. The reviewer finds no medical necessity for Left Shoulder Scope, AC Joint Resection, Subacromial Decompression RTC Repair.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Request for IRO dated 11/07/12
Receipt of request for IRO dated 11/08/12
Utilization review determination dated 10/30/12
Utilization review determination dated 11/07/12
MRI left shoulder dated 10/10/12
Clinical note dated 10/23/12
DWC form 73

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male who is reported to have sustained work related injuries to his shoulder on xx/xx/xx. He developed shoulder pain after moving a box. On 10/23/12 the claimant was seen. He reported occasional pain and discomfort over the anterolateral aspect of left shoulder. He is reported to have tenderness over the anterolateral acromion. The claimant was referred for MRI, which had been performed on 10/10/12. This study notes a high-grade tear involving the far anterior distal supraspinatus tendon extending into the superior subscapularis tendon. Tendinosis of the infraspinatus tendon was noted. There was medial subluxation of longhead of biceps tendon and tendinosis of intraarticular tendon. There were mild acromioclavicular joint degenerative changes. The claimant was recommended to undergo surgical intervention.

The initial review was performed. finds the claimant did not meet guidelines as he is not documented as failing some form of conservative treatment. He notes that there is no type of conservative treatment indicated in the submitted clinical notes and the request cannot be

certified as reasonable or medically necessary.

The appeal request was reviewed on 11/07/12. non-certified the request noting that although the patient has significant complaints of pain and inability to lift, push, or pull, the 10/23/12 progress note does not describe a comprehensive physical examination. He further notes that there is no substantive documentation establishing the failure of appropriate conservative treatment and upholds prior utilization review determination.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Besides a single clinical note and imaging study, there are no substantive records regarding conservative treatment to date or detailed physical examination, which would establish the medical necessity for the requested procedures. There is no evidence of impingement or positive orthopedic testing on examination irrespective of the imaging study. There is no detailed information nor a comprehensive physical examination to support the request. Based on the limited clinical information provided, the reviewer finds no medical necessity for Left Shoulder Scope, AC Joint Resection, Subacromial Decompression RTC Repair.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)