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IRO Cert # XX

DATE OF REVIEW: OCTOBER 16, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Medical necessity of proposed medical necessity of XX Shoulder open deep hardware removal, open biceps tenodesis-Outpatient (20680, 23430)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Orthopedic Surgery and is engaged in the full-time practice of medicine.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

XX Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a XXXX who was injured on XXXX, in a mechanism that was not denoted. The claimant was diagnosed with XX shoulder pain, XX XX, and XX shoulder displacement of a three-part XX XX fracture. An open reduction internal fixation of the XX XX XX fracture was performed XXXX. Treatment included physical therapy, a cortisone injection in the XX shoulder, activity modification, and medication. An evaluation on XXXX, documented complaints of XX shoulder pain. The claimant was twelve months out from open reduction internal fixation of the XX XX XX fracture. Medications included XXXX. The XX shoulder incision was well-healed. Elevation was 140 degrees. External rotation was 60 degrees. There was no pain or weakness with resisted rotator cuff strength testing. X-rays of the XX shoulder on XXXX, documented plate fixation of the XX XX fracture in satisfactory alignment.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE

NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE: There was a previous non-certification on XXXX, which indicated there was no notation of broken or failed hardware. There was no positive injection indicating hardware pain. There was a lack of appropriate physical examination findings. Official Disability Guidelines does not support routine hardware removal. There is no imaging showing broken hardware or a failed open reduction internal fixation. The records do not reflect a hardware injection with positive results. The physical examination and imaging did not show a biceps tendon tear, tendinosis, or SLAP tear. Per the Letter of Medical Necessity dated XXXX, there is a notation of hardware sensitivity and XX, but no pain is noted. Therefore, the request for a XX shoulder open deep hardware removal and open biceps is not certified as medically necessary as it does not meet the criteria per ODG guidelines.

Official Disability Guidelines Shoulder (updated XX) Not recommended for routine removal of XX except with exposed XX, XX, or XX ruling out other causes of pain such as infection and nonunion. Not recommended solely to protect against allergy, XX, or XX. Although hardware removal is commonly performed, it should not be considered a routine procedure. Criteria for Surgery XX (or XX): - History, physical examination, and imaging indicate significant shoulder biceps tendon pathology or rupture - After XX months (XX months for isolated XX) of failed conservative treatment (XX, XX, and XX) unless combined with acute rotator cuff repair - An alternative to direct repair for type II SLAP lesions (fraying, some detachment) and type IV XX tendon involved, vertical or bucket-handle tear of the superior labrum, extending into biceps) - Generally, XX lesions do not need any treatment - XX II XX (younger optional if overhead throwing athlete) - XX non-XX pathology, especially with concomitant rotator cuff repair; tenotomy is more suitable for older patients (past age 55)

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

☐ AHRQ- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

XXDWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

☐ INTERQUAL CRITERIA

XXMEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

XXODG- 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)