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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Dec/14/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right shoulder arthroscopy - SAD, CAL, SLAP Repair, Distal Clavicle, Brachial Plexus

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

M.D., 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines
Adverse Determination Letters, 11/10/09, 10/29/09
Medical Center, 9/9/09, 6/8/09, 10/15/08, 10/8/08, 10/1/08
Radiological Report, MRI of the Right Shoulder, 10/17/08
Operative Report, 7/15/09, 2/4/09
Dr. MD, 10/8/09
MD, 8/27/09, 6/23/09, 12/18/08, 11/4/08
MD, 11/30/09
MD, 9/11/09, 10/16/09
Physical Therapy, 7/30/09, 8/3/09, 7/16/09

PATIENT CLINICAL HISTORY SUMMARY

This is a male injured on xx/xx/xx after he fell off a ladder and injured his right shoulder. He had an MRI scan, which showed a partial thickness tear of the supraspinatus with no evidence of complete tear. There was a questionable thinning of the labrum, and tear could not be ruled out. The patient underwent therapy and had a shoulder arthroscopy with implantation of suture anchors for repair of the rotator cuff and apparently also debridement of the labrum. He has had a re-evaluation by a second surgeon for a second opinion evaluation who confirms that the surgical intervention has been correctly performed. He developed shoulder stiffness after the surgery and underwent manipulation under anesthesia. Based on the current exam records, it appears he has a functional range of motion at this

time. Current request is for repeat arthroscopy, acromioplasty, rotator cuff repair, SLAP repair, distal clavicle resection in all likelihood, and an unexplained procedure for the brachial plexus.

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

Based upon the medical records provided, this patient appears to have some rotator cuff weakness. It was felt there may be some radiculopathy. An MRI scan of the cervical spine has not been performed. An EMG/nerve conduction study, however, revealed probable mononeuropathy with carpal tunnel syndrome, which based upon the medical records appears to be asymptomatic. This reviewer could not identify from the record where the brachial plexus enters into the consideration of this particular case. As far as the surgery is concerned, the requesting physician does not explain why it is necessary to re-repair the rotator cuff that is already performed, re-perform an acromioplasty that has already been performed, and re-repair a labrum that has already been repaired. This request, as previous reviewers have noted, does not conform to the Official Disability Guidelines and Treatment Guidelines, and the requesting physician has not provided this reviewer with reasoning that would enable this reviewer to set aside the guidelines. It is for these reasons that the previous adverse determination(s) cannot be overturned. The reviewer finds that medical necessity does not exist for Right shoulder arthroscopy - SAD, CAL, SLAP Repair, Distal Clavicle, Brachial Plexus.

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)