

Clear Resolutions Inc.

An Independent Review Organization
6800 W. Gate Blvd., #132-323
Austin, TX 78745
Phone: (512) 879-6370
Fax: (512) 519-7316
Email: resolutions.manager@cri-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Nov/21/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Shoulder Rotator Cuff Repair, Subacromial Decompression, Platelet Gel Autograft, Slap Repair, and Biceps Tenotomy

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

M.D., Board Certified Orthopedic Surgeon

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 finds that Right Shoulder Rotator Cuff Repair, Subacromial Decompression, Slap Repair, and Biceps Tenotomy is medically necessary. The reviewer finds that Platelet Gel Autograft is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines
Request for IRO dated 10/25/11
Clinical records Dr. dated 06/13/11, 07/19/11
Utilization review determination dated 08/26/11
Utilization review determination dated 09/07/11
Peer review dated 04/18/11
Peer review dated 09/23/11
MRI shoulder dated 05/05/11
Radiographic report shoulder dated 03/03/11
MR arthrogram dated 05/19/11
Clinical record Dr. dated 08/05/11
Designated doctor evaluation dated 07/20/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who sustained injuries to her shoulder. She was lifting a table and she heard a pop in her right shoulder. She has continued to have right shoulder pain to palpation. She continues to have right shoulder pain despite conservative treatment. The submitted clinical records include MRI of shoulder performed on 05/05/11. This study notes hypertrophic changes of acromioclavicular joint with rotator cuff impingement, increased signal in distal supraspinatus tendon and rotator cuff tear is suspected. There is abnormal signal in superior labrum. Radiographs of the shoulder were negative. She ultimately

underwent MR arthrogram of the shoulder. This study notes hypertrophic changes in acromioclavicular joint with rotator cuff impingement, increased signal in the distal supraspinatus tendon. There is report of avulsion fracture of humeral head. Records indicate the claimant is continued under the care of Dr.. She continues to have positive Speed's test, positive SLAP test, and some pain with apprehension. She continues to have painful arc of motion. The record includes designated doctor evaluation.

Dr. performed the initial review on 08/26/11. He notes the MRI of the shoulder did not confirm a full thickness tear of rotator cuff or SLAP tear of labrum. He subsequently recommended MR arthrogram.

The subsequent review was performed by Dr. who non-certified the request on 09/07/11 noting the claimant had not exhausted lower levels of care as indicated in the guidelines such as physical therapy.

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

The submitted clinical records indicate the claimant sustained injury to her right shoulder while at her place of employment. The records clearly indicate the claimant has undergone exhaustive conservative treatment to include oral medications, physical therapy, and corticosteroid injections without relief. She has clear evidence of pathology on imaging studies. There is sufficient data to establish the failure of conservative treatment. The reviewer finds that Right Shoulder Rotator Cuff Repair, Subacromial Decompression, Slap Repair, and Biceps Tenotomy is medically necessary. The reviewer finds that Platelet Gel Autograft is not medically necessary. The platelet gel autograft is not considered medically necessary, as there is no significant peer reviewed literature to establish the use of platelet gel autograft results in any significant improvements in overall health outcomes.

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)**