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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Dec/10/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Outpatient right shoulder arthroscopy labral and rotator cuff repair

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

M.D. Board Certified Orthopedic Surgeon (Joint)

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 health care service in dispute. It is the opinion of the reviewer outpatient right shoulder arthroscopy labral and rotator cuff repair is indicated as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Preauthorization request dated 07/03/12
MR arthrogram of right shoulder with contrast dated 08/22/12
Fluoroscopic guidance for right shoulder intraarticular gadolinium injection dated 08/22/12
Physical therapy notes dated 08/23-09/28/12
Clinical notes dated 08/23/12-11/15/12
Utilization review determination dated 10/05/12
Utilization review determination dated 11/01/12

PATIENT CLINICAL HISTORY [SUMMARY]: The claimant is a male who injured his right shoulder secondary to a fall on xx/xx/xx. It was noted he sustained an anterior shoulder dislocation after the fall and underwent reduction of the shoulder. X-rays were taken which were initially read as negative. Subsequent MRI arthrogram on 08/22/12 revealed a healing fracture of proximal humerus greater tuberosity and probable SLAP lesion. There were mild degenerative changes at the acromioclavicular joint and relatively low lying acromion with mild rotator cuff tendinopathy and small focal partial undersurface tear of infraspinatus tendon. The claimant was treated conservatively with physical therapy, home exercise program, medications, and injection of the right shoulder on 11/05/12. Records indicate the

injection provided approximately 5-7 days of relief, and then the claimant began having increasing pain. Physical examination reported positive impingement sign. There was positive O'Brien's test, limited range of motion and markedly positive empty can test. The patient has pain with resisted movement with right arm above 70 degrees of flexion or 70 degrees of abduction.

A request for outpatient right shoulder arthroscopy, labral and rotator cuff repair was non-certified per review dated 10/05/12 noting that no formal imaging report was submitted for review. It was further noted it was unclear what non-operative care had been provided except for physical therapy which made it worse and narcotic medications. There was no documentation of full thickness rotator cuff tear or labral tear noted.

A reconsideration / appeal request for outpatient right shoulder arthroscopy labral and rotator cuff repair was non-certified per review dated 11/01/12 following peer to peer discussion. It was noted there was no documentation of lower levels of care of cortisone injection in shoulder or non-steroidal anti-inflammatory medications or muscle relaxants. It was noted there was no documentation if the claimant sustained a type II or type IV labral injury. There was no evidence of full thickness rotator cuff tear. Conservative treatment has not been exhausted at this point in time.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The claimant was injured when he fell and sustained an anterior dislocation of the right shoulder. He underwent reduction of the shoulder. Initial x-rays were read as negative, but subsequent MRI showed healing fracture of proximal humerus greater tuberosity and probable SLAP lesion. There were also mild degenerative changes at AC joint with relatively low lying acromion and mild rotator cuff tendinopathy with small focal partial undersurface tear of infraspinatus tendon. The claimant was treated conservatively with physical therapy, home exercise program, medications, and injection of the right shoulder which provided significant but temporary relief. On examination the claimant had significant reduction in range of motion. There was clicking and popping with external rotation. There was markedly positive O'Brien's test and markedly positive empty can test. There was pain with resisted movement above 70 degrees of flexion or 70 degrees of abduction. Noting lack of significant improvement in response to conservative treatment, objective findings on imaging studies, and physical examination findings, it is the opinion of the reviewer outpatient right shoulder arthroscopy labral and rotator cuff repair is indicated as medically necessary.

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)