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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Nov/27/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpt Right Shoulder Acromioplasty / Arthroscopic Decompression of Subacromial Space with Partial Arthroscopic Debridement / Open Repair Acute Rupture Rotator Cuff

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

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Request for IRO 11/01/12
Receipt for request of IRO 11/07/12
Utilization review determination 10/08/12
Utilization review determination 10/25/12
Clinical records 07/07/12-11/12/12
Radiographic report shoulder 07/10/12
MRI shoulder 07/20/12
Letter of appeal 10/11/12
Physical therapy treatment records

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is reported to have sustained work related injuries to the right shoulder. On this date, he was reported to have been struck by a piece of equipment causing him to fall on to his right shoulder and he was later seen at an urgent care facility and then came under the care of. The claimant has a history of a proximal biceps tendon repair and radiographs of the shoulder showed metal hardware in place and what appeared to be a Richard staple in the bicipital groove and he received a corticosteroid injection and was referred for MRI. On 07/20/12, the claimant underwent MRI of the right shoulder and this study noted a metallic object in the proximal right humerus, AC joint arthropathy and impingement, severe supraspinatus tendinopathy, subscapularis tendinopathy, and no evidence of a full thickness

rotator cuff tear. The claimant was subsequently seen in follow up on 08/02/12 and provided an exercise program and referred to physical therapy. When seen on 08/30/12, it was reported that the injection had helped somewhat in the shoulder and he started physical therapy which made his shoulder pain worse and he was recommended to have another subacromial injection when seen in follow up on 09/27/12. The claimant reported only a three day benefit from the previous injection. He was noted to have pain with flexion past 90 degrees. Positive Hawkin's, O'Brien and Neer tests. The claimant was recommended to consider arthroscopic subacromial decompression of the shoulder and the request included a letter of appeal dated 10/11/12 and he noted that the request was not approved. He reported that apparently her logic was based in the Official Disability Guidelines and the stated reason for rejection was the lack of failure of conservative treatment. The most recent clinical note is dated 11/12/12 and the claimant was noted to be working full time as a drilling supervisor. He had complaints of pain with elevation.

The initial review was performed on 10/08/12 and non-certified the request noting that treatment to date has included activity modification, medication, physical therapy, and corticosteroid injections. She noted that there was no documentation of additional objective findings (weakness or absent abduction, tenderness over the rotator cuff or anterior acromial area, and temporary relief of pain with anesthetic injection and she further notes that Official Disability Guidelines require the failure of three to six months of conservative treatment).

The appeal request was reviewed on 10/25/12 and non-certified the request and noted that the previous reviewer non-certified the request as there was no documentation of additional objective findings such as weak or absent abduction, tenderness over the rotator cuff, or anterior acromial area and temporary relief of pain with anesthetic injection in conjunction with the failure of three to six months of conservative management and he noted that a physical therapy evaluation there was no documentation of the total number of visits completed, duration of the course of treatment, and the compliance of the patient and he found insufficient data to establish the medical necessity of the request and subsequently upheld the prior denial.

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

The request for right shoulder acromioplasty, arthroscopic decompression of the subacromial space with partial arthroscopic debridement, and open repair of an acute rotator cuff tear is not supported by the submitted clinical information. The available clinical records indicate that the claimant sustained an injury to the shoulder as the result of a slip and fall. The records indicate that the claimant has received conservative management of oral medications and physical therapy and the serial records do not provide detailed information regarding the response to therapeutic measures. There is no new information provided which would substantiate the medical necessity of the request and override the prior utilization review determinations. Therefore, based on the information provided, the prior utilization review determinations are upheld and the request is not supported as medically necessary per the Official Disability Guidelines.

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)