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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/23/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Right Shoulder Arthroscopy for Rotator Cuff Repair, Decompression & Mumford

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

M.D., Board Certified 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

Official Disability Guidelines
Appeal preauth UR 11/18/11
Surgery request 10/25/11
Appeal surgery request 11/10/11
Initial preauth UR 10/28/11
Office notes Dr. 06/24/11-11/07/11
MRI right shoulder 06/07/11
Office notes Dr. 05/25/11-06/08/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who reportedly was injured on xx/xx/xx as he was reaching and pulled a wrench. MRI of the right shoulder on 06/07/11 reported partial thickness tearing and/or tendinopathy involving both supraspinatus and infraspinatus tendons, with no complete tears or retraction evident. Hypertrophic arthropathy was noted involving acromioclavicular joint. Mild fluid signal was noted within subacromial / subdeltoid bursa. Probable underlying osteoarthritic type degenerative changes involving glenohumeral joint were noted, as well as probable mild degenerative changes involving glenoid labrum, with no distinct tearing evident. Physical examination noted the claimant to be 5'11" tall and 225 lbs. There were no signs and symptoms of infection or DVT. Neurovascular exam is intact in right upper extremity. Range of motion testing reported forward flexion 120, abduction 120, internal rotation and external rotation 60 degrees. There is positive Hawkins, positive supraspinatus sign. The claimant was recommended to undergo right shoulder arthroscopy.

An initial preauthorization review dated 10/28/11 recommended adverse determination of request for right shoulder arthroscopy for rotator cuff repair, decompression, and Mumford. It was noted the claimant sustained injury when he was reaching and pulled a wrench. He

complained of continued pain in the right shoulder and reported numbness to entire forearm and hand intermittently. Physical examination showed tenderness to palpation over the acromioclavicular joint and lateral clavicle. Range of motion was decreased. The claimant was shown shoulder range of motion exercise and given Tramadol for pain. MRI of right shoulder on 06/11 showed partial thickness tear and / or tendinopathy. Dr. subsequently saw the claimant on 06/24/11 and physical examination showed decreased range of motion. There was positive Hawkins sign and positive supraspinatus sign. Findings were discussed and home exercise program was shown to claimant. He was recommended to attend physical therapy and not use right arm. He was injected with Depomedrol into the right shoulder. Medications (Mobic and Tramadol) were prescribed for pain.

He completed 5 physical therapy sessions. He continued to improve slowly with physical therapy. Physical examination on 09/12/11 showed decreased range of motion, positive Hawkins sign, and positive supraspinatus sign. It was recommended the claimant undergo right shoulder arthroscopy for rotator cuff repair and decompression with Mumford. It was determined the ODG guidelines state cervical pathology should be evaluated and ruled out. There is documentation of numbness to entire hand and forearm, but no documentation of any evaluation of cervical spine. Treatment has been 5 sessions of physical therapy, injection into shoulder, anti-inflammatory and narcotic pain medications. The claimant has complaints persistent with rotator cuff pathology. MRI demonstrated partial tearing of rotator cuff. It is unclear what benefit the injection had provided, i.e. impingement test and how this relates to any potential cervical spine complaints. Based on the information available, shoulder arthroscopy is not indicated and appropriate.

An appeal preauthorization review was performed on 11/18/11 and adverse determination recommended. It was noted that symptoms of right hand and arm numbness suggest potential pathology that has not been adequately evaluated. There is documentation of range of motion alterations and changes. The claimant's shoulder range of motion initially improved and then worsened. There has been recent local anesthetic injection with corticosteroid medication; however, the result has not been documented. Prior denial of this surgical preauthorization request was appropriate, and in the absence of additional information, adverse determination is recommended.

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

This claimant is noted to have sustained injury to right shoulder on xx/xx/xx. His condition has been refractory to 6 months of conservative treatment, and his condition continues to worsen. He has decreased range of motion despite home exercise program and physical therapy. He has weakness, abduction, and positive pain on crossed abduction, and pain on AC joint. He has positive supraspinatus sign, indicative rotator cuff tear, and positive Neer impingement sign. There is pain with palpation over rotator cuff insertion. He has painful arc of motion from 90-125 degrees with weak abduction and pain with crossed abduction. He had excellent relief of shoulder pain with injection, indicating there are no cervical radicular signs. Pain returned over course of a 3-week period. He had neurology clearance for head and neck injury. Given the objective findings on MRI with evidence of partial thickness tear of rotator cuff, findings on clinical examination, and failure of conservative treatment, the claimant meets ODG criteria for right shoulder arthroscopy. The reviewer finds there is medical necessity for Right Shoulder Arthroscopy for Rotator Cuff Repair, Decompression & Mumford. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be overturned.

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)