

SENT VIA EMAIL OR FAX ON
Jan/20/2012

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/20/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

OP Right Shoulder Arthroscopy with Debridement and Labral Repair

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Request for IRO dated 01/05/12

Utilization review determination dated 12/14/11

Utilization review determination dated 01/04/12

MRI right shoulder dated 09/21/11

Radiographic report right shoulder dated 07/06/11

Clinic note Dr. dated 07/06/11

Clinic note Dr. dated 08/30/11, 09/26/11

Clinic note Dr. dated 11/14/11, 12/21/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who is reported to have sustained work related injuries on xx/xx/xx. It is reported he was playing football and another player sustained contusion and slight hyperextension to his elbow and landed on his right shoulder. He reported immediate onset of pain and was unable to continue playing. Records indicate the claimant was seen by Dr.

and diagnosed with right elbow pain and right shoulder pain. Radiographs were performed on 07/06/11 which showed no evidence of fracture. The claimant was referred to Dr. on 08/30/11. It is reported the claimant has attempted range of motion exercises for the shoulder and continues to have pain especially with overhead activity. He has previous history of left ankle surgery. On physical examination he has normal range of motion of the neck with negative Spurling's sign. Examination of the shoulder reveals positive impingement sign and positive cross arm adduction test. Crepitation was noted in subacromial space. He was tender over acromioclavicular joint in biceps tendon region. Forward elevation is to 165 degrees. External rotation is to 65 degrees. Internal rotation is to T12. External rotation strength testing along with abduction strength testing did reveal weakness. Examination of the elbow reveals symmetric range of motion when compared to contralateral side. There is evidence of traumatic bursal formation posteriorly. Radiographs do not reveal any significant degenerative changes. The claimant is diagnosed with rotator cuff weakness, possible tear, impingement syndrome, acromioclavicular joint lysis with hypertrophic changes creating medial outlet stenosis and right elbow traumatic olecranon bursitis. The claimant was subsequently referred for MRI of shoulder on 09/21/11. This study notes hypertrophy and edema around acromioclavicular joint capsule, tiny subacromial spur is present. The coracoacromial ligament is intact. There is mild subacromial subdeltoid bursitis. There is small undersurface foot print tear of supraspinatus which measures approximately 6 mm. The cuff tendons are otherwise normal. No tendon retraction is present. The long head of biceps is normal. The claimant was seen in follow-up on 09/26/11 for continued difficulty with right shoulder. He was seen by designated doctor who placed him at MMI. There is no substantive change in physical examination. He has partial thickness tear. He is reported to be moving to area and opined to have not reached maximum medical improvement. On 11/14/11 the claimant was seen by Dr.. The claimant is reported to have right shoulder dysfunction and recently moved to. He's 6'2" 245 pounds. He's noted to have no AC joint tenderness mildly positive impingement sign rotator cuff strength is graded as 5/5 abduction external rotation with some snapping and popping full abduction with pain full internal rotation with pain and positive O'Brien's test. MRI shows partial rotator cuff tear. He subsequently recommends arthroscopy with possible labral repair.

The initial review was performed by Dr. on 12/14/11 who non-certified the request noting that the records elaborate on claimant complaining of shoulder pain with associated range of motion deficits. He notes that imaging studies were not included for his review and there is a lack of information regarding previous conservative treatments to include physical therapy. Based on the information he was provided the claimant did not meet guidelines per the Official Disability Guidelines. A subsequent appeal review was performed by Dr. who non-certified the request noting that the record did not include a recent updated comprehensive physical examination. He notes that there was no documentation of pain with active arc of motion. He further notes a lack of information regarding conservative management. He notes that there's no documentation of weakness in abduction or atrophy or tenderness over the rotator cuff. Further he notes that there's no documented evidence of physical therapy or physical therapy progress notes showing the lack of progress.

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

The request for right shoulder arthroscopy with debridement labral repair is not supported as medically necessary. The submitted clinical records suggest that the claimant has had minimal treatment. He appears to have largely done a self directed home exercise program. There's no evidence of supervised physical therapy in the clinical record. Further there's no indication that the claimant underwent local corticosteroid injections. There is a paucity of physical examination findings on the most recent clinical note dated 11/14/11. In the absence of more detailed clinical information clearly establishing the failure of conservative treatment and noting the lack of examination findings in correlation with imaging the requested procedure was appropriately denied and the previous utilization review determinations are upheld.

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)