

Independent Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Sep/28/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left Shoulder Arthroscopy, AC Joint Resection, Subacromial Decompression; Rotator Cuff Repair

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

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Physical therapy notes dated 05/13/12 and 05/30/12
Clinical notes dated 04/03/12 – 08/09/12
MRI left shoulder dated 05/01/12
Prior review dated 08/17/12 and 09/07/12
Cover sheet and working document

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx. The patient reported a pop in the left shoulder with development of pain in the deltoid. The patient was evaluated on 04/03/12 and physical exam revealed positive impingement signs with pain on internal and external rotation. The patient also reported pain with abduction of the left shoulder. Radiographs of the left shoulder were stated to show a subacromial hook off the anterior acromion with significant acromial clavicular joint arthrosis. MRI studies were recommended and the patient was referred for physical therapy. MRI of the left shoulder dated 05/01/12 revealed severe acromioclavicular joint arthropathy and inflammatory changes. Early grade 3-4 glenohumeral chondromalacia was noted and a small osteochondral defect was present. Tendinitis of the rotator cuff was identified and no tearing was reported. There is an irregular appearance of the anterior superior labrum possibly demonstrating a septal labral injury. Patient was placed on anti-inflammatories and follow up on 08/09/12 indicated the patient did not have any significant improvements with physical therapy after 6 sessions. No improvements with

medications were reported. Physical exam at this visit revealed tenderness to palpation of the anterior lateral acromion and the acromial clavicular joint. The patient reported no improvements with steroid DosePak.

The request for rotator cuff repair, acromial clavicular joint resection and subacromial decompression was denied by utilization review on 08/17/12 as there was no indication that corticosteroid injections were attempted and there was no updated detailed physical examination of the right shoulder.

The request was again denied by utilization review on 09/07/12 as there was no updated evaluation for provocative testing of the rotator cuff or AC joint and no diagnostic injection tests were performed.

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

The request for left shoulder arthroscopy, AC joint resection, subacromial decompression, and rotator cuff repair is not supported as medical necessity based on the clinical documentation provided for review and guidelines on recommendations. The patients' most recent physical exam was limited and did not fully evaluate the patients' left shoulder. No positive impingement signs were reported on the most recent physical exam. Although the patient did not respond to physical therapy or medications, there is no documentation regarding a diagnostic injection to the subacromial space as indicated by current evidence based guidelines. Additionally, the MRI of the left shoulder did not clearly identify any rotator cuff tearing that would reasonably require repair. As the clinical documentation provided for review does not meet guideline recommendations for the request, medical necessity is not established, and the previous denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES