

Pure Resolutions LLC

An Independent Review Organization
990 Hwy 287 N. Ste. 106 PMB 133
Mansfield, TX 76063
Phone: (817) 405-0514
Fax: (512) 597-0650
Email: manager@pureresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Nov/05/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient Surgery for RCR, DCR, and SAD

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
X-ray right shoulder 08/29/13
MRI 05/24/13
Clinical notes 09/23/13 and 10/02/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury to his right shoulder. X-ray of the right shoulder dated 11/12/12 revealed osteoarthritic changes at the acromioclavicular joint. Subtle downsloping of the acromion was noted. MRI of the right shoulder dated 05/24/13 revealed a focal tear at the insertion foot plate without full thickness tear or disruption at the supraspinatus tendon. A small focal tear was also noted at the biceps tendon with surrounding fluid. No full thickness tear was noted. Hypertrophy of the acromioclavicular articulation with degenerative changes was noted. Clinical note dated 09/23/13 indicated the patient having a 10 month history of right shoulder pain. The patient had decreased strength with pain radiating and popping sensation. Cortisone shot provided some benefit. The patient also underwent 12 physical therapy visits with benefit. Pain was exacerbated with reaching. The patient utilized Aleve on a PRN basis. Upon exam the patient demonstrated 180 degrees of forward elevation and 90 degrees of abduction. The patient demonstrated full strength with all rotates throughout the rotator cuff. Crepitus was noted at the acromioclavicular joint. The patient had minimally positive O'Brien test. The patient was recommended for rotator cuff repair and operative procedure at the right shoulder at this time. Clinical note dated 10/02/13 indicated the patient having severe shooting pains in the right

shoulder. The note mentioned an 80% tear of the supraspinatus tendon. Previous utilization review dated 10/01/13 indicated the denial for a rotator cuff repair, distal clavicle resection, and subacromial decompression as no information was submitted regarding completion of all conservative measures including medication therapy. Utilization review dated 10/14/13 resulted in a denial for the surgical procedures as no information was submitted regarding specific complaints of pain with active arc of motion. No information was submitted confirming completion of a full course of conservative treatment.

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

Clinical notes indicated the patient having ongoing complaints of right shoulder pain with associated range of motion deficits. Rotator cuff repair and subacromial decompression are indicated after a completion of a three month course of conservative care and the patient continues with specific clinical findings indicating pain with active arc of motion from 90-130 degrees and the patient has specific complaints of pain at night. Clinical notes indicate the patient completing 12 sessions of physical therapy. However, no information was submitted confirming a full completion of a three month course of conservative treatment. No information was submitted regarding specific clinical findings indicating pain with active arc of motion or at night. As such, it is the opinion of the reviewer that the request for outpatient surgery for rotator cuff repair, distal clavicle resection, and subacromial decompression is not recommended 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)