

True Decisions Inc.

An Independent Review Organization
2002 Guadalupe St, Ste A PMB 315
Austin, TX 78705
Phone: (512) 879-6332
Fax: (214) 594-8608
Email: rm@truedecisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Oct/1/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Exam under Anesthesia Diagnostic, Arthroscopy, Decompression Acromioclavicular planning, excision debridement, repair rotator Cuff Biceps Tenodesis

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

Board Certified Orthopedic Surgeon

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

Clinical reports dated 04/03/13 – 07/29/13

Physical therapy reports dated 05/03/13 & 05/23/13

MRI of the left shoulder dated 06/12/13

Prior reviews dated 07/12/13 & 08/26/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx. The patient felt a pop in the left shoulder. The patient was initially seen on 04/03/13 with complaints of pain in the left deltoid insertion and proximal humerus. Physical examination demonstrated point tenderness to the deltoid with some pain over the biceps. No motor weakness was identified. Radiographs were stated to show no evidence of fractures. The patient was initially assessed with subdeltoid bursitis with tendinitis. The patient was placed on anti-inflammatories and referred for physical therapy. The patient was seen for physical therapy through May of 2013. MRI studies of the left shoulder completed on 06/12/13 showed a mild type 2 acromion with no evidence of glenoid labral tearing. There was fluid within the subdeltoid and subacromial bursa consistent with bursitis. There was a near complete tear of the subscapularis tendon at the insertion and there was thickening and increased intrasubstance within the intraarticular portion of the biceps tendon indicating tendinosis. Partial thickness tearing of the supraspinatus tendon was noted. Follow up on 06/19/13 stated that the patient continued to have limited range of motion in the left shoulder as well as weakness despite physical

therapy. Physical examination did show pain with range of motion in the left shoulder. There was limited flexibility with range of motion; however, no specifics were given. The patient was recommended for diagnostic arthroscopy at this visit. The patient returned on 07/25/13. The report indicated that the patient had not improved with injections, the use of anti-inflammatories, or physical therapy. Physical examination demonstrated tenderness to palpation over the biceps tendon as well as over the acromioclavicular joint. There was mild limitation of range of motion of the left shoulder due to pain. There were positive impingement signs as well as a positive cross chest adduction sign. The patient did report temporary benefit from injections only. The patient was recommended for work restrictions until surgical management can be performed. Follow up on 07/29/13 demonstrated persistent pain and loss of range of motion of the left shoulder with positive impingement signs and tenderness over the acromioclavicular joints and over the biceps tendon.

The request for left shoulder diagnostic arthroscopy for acromioclavicular decompression and planning, excision debridement, rotator cuff repair, and biceps tenodesis was denied by utilization review on 07/12/13 as there was no documentation regarding conservative treatment.

The request was again denied by utilization review on 08/26/13 as there were limited objective findings to support the surgical requests submitted.

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

The patient has been followed for ongoing complaints of left shoulder pain that has not improved with physical therapy, the use of anti-inflammatories, or in the long term from injections. The patient reported some reduction in symptoms with the initial injection. Imaging studies did show almost complete rupture of the subscapularis at the tendon insertion with partial thickness tearing of the supraspinatus tendon. There were findings consistent with biceps tendinitis and there was a type 2 acromion present. The patient's physical examination findings were positive for limited range of motion as well as positive impingement and cross body adduction signs. Per current evidence based guidelines, arthroscopic treatment of partial thickness rotator cuff tears and impingement is recommended only when patients have exhausted a reasonable course of conservative treatment extending up to 6 months. In this case, the patient received physical therapy for approximately 1 ½ months with no response. There was a positive result from diagnostic injections per the clinical reports and the patient was utilizing anti-inflammatories. Given the positive physical examination findings noted on the most recent evaluations and as there is extensive pathology in the rotator cuff as well as the biceps tendon, it is this reviewer's opinion that medical necessity is established for the diagnostic arthroscopy for acromioclavicular decompression, excision debridement, repair of the rotator cuff, as well as biceps tenodesis. As such, the prior denials are 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)