

Clear Resolutions Inc.

An Independent Review Organization

6800 W. Gate Blvd., #132-323

Austin, TX 78745

Phone: (512) 879-6370

Fax: (512) 519-7316

Email: resolutions.manager@cri-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Apr/22/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: right shoulder arthroscopy, subacromial debridement, possible biceps tendon, tendonitis, possible glenoid debridement vs. repair

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M. D. 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. It is the opinion of this reviewer that the requested right shoulder arthroscopy, subacromial debridement, possible biceps tendon, tendonitis, possible glenoid debridement vs. repair is not recommended as medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical notes 09/12/12-03/19/13

MRI right shoulder 11/02/12

Therapy notes 11/30/12-01/03/13

Previous utilization reviews 01/15/13 and 03/01/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his right shoulder. Clinical note dated xx/xx/xx detailed the patient complaining of a one month history of right shoulder pain. Clinical note dated xx/xx/xx detailed the patient complaining of a one month history of right shoulder pain. The patient stated that there was an increase in pain when working with overhead activities. The patient described pain specifically at the anterior aspect with radiation into the posterior portion of the shoulder. The patient rated his pain as 8/10 at that time. Upon exam, the patient demonstrated 90 degrees of right shoulder abduction and 100 degrees of passive abduction. The patient demonstrated 5/5 strength throughout the shoulder. Clinical note dated xx/xx/xx detailed the patient continuing with right shoulder pain specifically with which was exacerbated with overhead activities. The patient continued with 90 degrees of both abduction and flexion at the shoulder. Clinical note dated 10/16/12 detailed the patient utilizing over the counter medications for ongoing pain relief. Tenderness was noted over the rotator cuff. No strength deficits were noted. Clinical note dated 10/30/12 detailed the patient continuing with anterior and posterior aspect shoulder pain on the right. The patient demonstrated 160 degrees of flexion and 140 degrees of abduction. MRI of the right shoulder dated 11/02/12 revealed degenerative changes along the acromioclavicular joint. No biceps tendon was noted to be within the bicipital groove.

The short head of the biceps tendon was noted to be well maintained. Lobulated pararegular cyst was noted at the posterior and inferior portion of the glenoid labrum. Clinical note dated 11/06/12 detailed the patient continuing with right shoulder pain. The patient demonstrated near full range of motion. However, pain was elicited with 90 degrees of both abduction and flexion. Clinical note dated 11/27/12 detailed the patient completing 12 visits to date. Clinical note dated 01/08/13 detailed the patient continuing with a constant aching sensation at the right shoulder. The patient was utilizing Tylenol for pain relief. The patient continued with near full range of motion throughout the shoulder. Clinical note dated 03/19/13 detailed the patient continuing with right shoulder pain. The patient completed an additional round of physical therapy for a total of four weeks. The patient described the pain as moderate. The patient continued with light duty.

The previous utilization review dated 01/15/13 resulted in a denial for a right shoulder arthroscopy with a subacromial debridement with a possible biceps tendon and possible glenoid debridement versus repair secondary to secondary to a lack of consistent symptomatic findings involving a labral tear. Additionally, a lack of clear correlation of symptoms was noted by exam. The patient was recommended for a 3-month course of conservative treatment to include a repeat subacromial injection which was not completed.

The utilization review dated 03/01/13 for a surgical intervention at the right shoulder including subacromial debridement also resulted in a denial secondary to a lack of consistent findings indicating AC joint involvement as well as a lack of imaging studies confirming the patient's pathology.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation submitted for review elaborates the patient complaining of right shoulder. A shoulder arthroscopy with subacromial debridement and possible glenoid debridement versus repair would be indicated provided the patient meets specific criteria to include pathology confirmed by imaging studies. Additionally, a full 3-months course of physical therapy would need to be completed prior to a surgical intervention. The imaging studies do confirm a cyst in the labral region; however, no tear was noted. Additionally, it is unclear if the patient completed any additional physical therapy beyond the completed course noted in the documentation. As no imaging studies were submitted confirming the patient's right shoulder pathology and taking into account the lack of information regarding the patient's completion of a 3-month course of conservative therapy, this request does not meet guideline recommendations. As such, it is the opinion of this reviewer that the requested right shoulder arthroscopy, subacromial debridement, possible biceps tendon, tendonitis, possible glenoid debridement vs. repair is not recommended as medically necessary and the prior denials 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)