

Becket Systems

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/14/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: rotator cuff repair / superior labrum anterior posterior repair, diagnostic arthroscopy with debridement, sub-acromial decompression, left shoulder arthroscopy examination under anesthesia

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 request rotator cuff repair / superior labrum anterior posterior repair, diagnostic arthroscopy with debridement, sub-acromial decompression, left shoulder arthroscopy examination under anesthesia is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The claimant is a male who reportedly was injured on xxxxx secondary to a motor vehicle accident. He complains of left shoulder pain. Reference is made to a MRI of the left upper extremity (date unknown). This study reportedly showed a full-thickness supraspinatus tear with no retraction and a minor SLAP tear; however, no official radiology report was submitted for review. X-rays of the left shoulder performed on 09/17/12 revealed no acute fracture or dislocation with mild joint space narrowing and osteophytes at the inferior glenoid. Mild hypertrophic changes at the AC joint were also noted. It appears that the claimant was treated conservatively with anti-inflammatory medications and physical therapy.

A request for left shoulder arthroscopy with debridement, sub-acromial decompression,

rotator cuff repair, and superior labrum anterior posterior repair was non-certified on 01/11/13, noting that pathology within the labrum on MRI. The reviewer noted that on examination there was tenderness over the acromioclavicular joint, with drop arm test strength 4+/5. The claimant was treated with physical therapy, frequency unknown, which did not help him much. He also had unspecific over the counter NSAIDs. The request was recommended for non-certification secondary to inability to modify the current request.

An appeal request was non-certified on 02/05/13, noting that the records provided for review did not contain the MRI report to be able to discern the specific pathology and therefore non-certification of appeal request was recommended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The records reflect that the claimant was injured secondary to motor vehicle accident on xx/xx/xx resulting in injury to the left shoulder. The claimant was treated conservatively with physical therapy of unknown frequency, as well as unspecified NSAIDs. The orthopedic clinical notes reference an MRI of the left upper extremity as showing a full thickness supraspinatus tear and a minor SLAP tear, but no radiology report was provided in order to evaluate specific pathology of the left shoulder. As such, it is the opinion of this reviewer that the request rotator cuff repair / superior labrum anterior posterior repair, diagnostic arthroscopy with debridement, sub-acromial decompression, left shoulder arthroscopy examination under anesthesia does not meet Official Disability Guidelines, and medical necessity is not established.

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)