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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jul/30/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Left Shoulder Scope with SAD RTC Repair vs Debridement

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
Clinical notes 12/19/12-07/10/13
MRI left shoulder 02/22/13
Manual muscle testing 03/07/13
Procedure note 03/19/13
Therapy note 04/29/13 and 06/21/13
MRI left shoulder 08/04/13
Previous utilization reviews 06/14/13 and 06/27/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury to his left shoulder. Clinical note dated 12/19/12 detailed the patient stating that the initial injury occurred when he was lifting resulting in left shoulder pain. The patient described the pain as a moderate, constant, and throbbing sensation. MRI of the left shoulder dated 02/22/13 revealed a full thickness anterior supraspinatus tendon tear with 1.2cm retraction. Subscapularis tendinopathy was also noted. Operative report dated 03/19/13 detailed the patient undergoing a left shoulder arthroscopy with subacromial decompression and repair of supraspinatus. Therapy note dated 04/29/13 detailed the patient undergoing five physical therapy sessions to date. Clinical note dated 05/06/13 detailed the patient utilizing hydrocodone and cyclobenzaprine for ongoing pain relief. Upon exam no malalignment or atrophy was noted at the left shoulder. Clinical note dated 05/30/13 detailed the patient showing no significant findings involving the right shoulder. No tenderness was noted at the substernal notch. The MRI of

the left shoulder dated 06/04/13 revealed evidence of a repair of the distal supraspinatus tendon and studies mentioned recurrent full thickness tear. A small to moderate amount of fluid was noted in the subacromial and subdeltoid bursa. No evidence of a labral tear was noted. The patient had a normal biceps tendon appearance. Therapy note dated 06/21/13 detailed the patient completing 15 physical therapy sessions to date. Clinical note dated 07/10/13 detailed the patient having a painful arc of motion at 90 degrees. The patient demonstrated failure to progress with the left shoulder despite conservative treatment.

The previous utilization review dated 06/14/13 detailed the request for left shoulder scope with a subacromial decompression and rotator cuff repair as no information had been submitted regarding completion of all conservative care.

Previous utilization review dated 06/27/13 for a subacromial decompression and rotator cuff repair at the left shoulder resulted in a denial secondary to the patient having not completed a full course of conservative treatment.

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

Clinical documentation submitted for review notes the patient complaining of ongoing left shoulder pain despite a previous surgical intervention. Official Disability Guidelines recommend both subacromial decompression and rotator cuff repair provided that the patient meets specific criteria, including completion of all conservative treatment including three to six month course of physical therapy. The patient completed six weeks of conservative treatment; however, no information was submitted regarding additional treatments addressing left shoulder complaints. Given that no information was submitted confirming the patient's completion of a three-month course of physical therapy, this request does not meet guideline recommendations. As such, it is the opinion of this reviewer that the request for a left shoulder scope with subacromial decompression, and rotator cuff repair versus debridement is recommended as non-certified.

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