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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 arthroscopy / debridement / SAD / momford rotator cuff repair

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

Board Certified Orthopedic Surgery

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
MR arthrogram of the left shoulder dated 08/30/10
MR arthrogram of the left shoulder dated 12/09/10
MR arthrogram of the left shoulder dated 11/07/11
Radiographs of the left shoulder dated 03/30/12
Clinical notes dated 04/30/12 – 07/02/13
Operative report dated 06/07/12
MRI of the left shoulder dated 07/27/12
Procedure note dated 05/07/13
Prior reviews dated 05/16/13 & 06/20/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who initially sustained an injury on xx/xx/xx. The patient is noted to have undergone multiple prior left shoulder rotator cuff repairs with the most recent operative procedure being a manipulation under anesthesia performed on 06/07/12. Postoperative MRI studies of the left shoulder completed on 07/27/12 showed a recurrent tear of the anterior fibers of the humeral attachment with a combined partial and full thickness tear of the rotator cuff. No bony impingement was present in the left shoulder. There was concurrent treatment for CRPS symptoms with severe pain, swelling, allodynia, and mottling discoloration. The patient was recommended for stellate ganglion blocks which were performed on 05/07/13. The patient initially reported pain relief followed by gradual return of symptoms. The clinical evaluation on 06/21/13 indicated that the patient continues to have left shoulder and left

upper extremity pain. Physical examination demonstrated limited range of motion in the left shoulder secondary to pain with positive impingement signs. There was weakness present with a positive drop arm sign and painful Speed's tests. recommended repeat stellate ganglion blocks on 06/25/13.

The request for a left shoulder arthroscopy to include debridement, subacromial decompression, Mumford procedure, and rotator cuff repair was denied by utilization review on 05/16/13 as there was lack of objective documentation of conservative care following the most recent manipulation under anesthesia procedure. Given the patient's prior surgical interventions to the left shoulder, further surgery was not recommended.

The procedures were again denied by utilization review on 06/20/13 as there was no documentation in regards to recent conservative treatment.

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 despite multiple surgical procedures including a recent manipulation under anesthesia in July of 2012. Post-procedure MRI studies of the left shoulder did identify recurrent tearing of the rotator cuff without evidence of bony impingement. The patient's most recent physical examination findings did reveal significant weakness in the right shoulder with a positive drop arm sign and a positive Speed's sign. There were impingement signs noted on physical examination. The clinical documentation submitted for review did not document any recent attempts at conservative treatment in regards to rehabilitation of the left shoulder. Given the patient's prior multiple rotator cuff repairs, it is unlikely at this point in time that the patient would receive any further benefit from additional surgical interventions. Furthermore, the patient now has a coexisting diagnosis of possible CRPS for which he is receiving stellate ganglion blocks. Given the patient's CRPS symptoms that appear to be secondary to the previous surgical intervention, it is unclear at this point in time how further surgery will reasonably result in an improved functional status for the patient. As such, it is this reviewer's opinion that the proposed procedures are not medically necessary per guidelines and the prior denials are upheld.

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