

Clear Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Feb/05/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: arthroscopy, shoulder, surgical; debridement, extensive

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D. O. Board Certified Surgery, Fellowship trained Orthopedic Hand and Upper Extremity 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. It is the opinion of the reviewer that this request for arthroscopy, shoulder, surgical; debridement, extensive does not meet guideline recommendations and is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Clinical notes dated 05/23/12, 07/11/12, 08/14/12, 08/21/12, 09/21/12, and 10/19/12

Operative report dated 04/16/12

Left shoulder x-ray dated 08/24/12

Therapy notes dated 04/23/12, 06/04/12, 06/29/12, 08/10/12, 09/21/12, and 10/12/12

Previous utilization reviews dated 11/01/12 and 11/09/12

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury regarding his left shoulder. The operative report dated 04/16/12 details the patient undergoing a left shoulder arthroscopic debridement with a distal claviclectomy and an acromioplasty. The therapy note dated 04/23/12 details the patient initiating postoperative physical therapy for the left shoulder. The patient rated his pain at that time as 4-6/10. The clinical note dated 05/23/12 details the patient stating that he was experiencing pain with weight bearing. The patient was able to demonstrate 140 degrees of flexion and 90 degrees of abduction; both directions elicited pain. The therapy note dated 06/04/12 details the patient continuing with 4-6/10 pain. The patient was noted to be able to work with light duty restrictions at that time. Per clinical note dated 07/11/12, the patient continued with weakness and pain. The patient was able to demonstrate 180 degrees of flexion, 110 degrees of abduction, and 90 degrees of external rotation at that time. The note details the patient utilizing Celebrex for pain relief. The therapy note dated 08/10/12 details the patient being able to demonstrate 155 degrees of flexion, 158 degrees of abduction, and 62 degrees of external rotation. Pain was noted with flexion and abduction. The clinical note dated

08/14/12 details the patient continuing with complaints of pain, specifically with overhead activities. The patient continued with a positive Neer and Hawkins tests. Mild crepitus was also noted. The patient was noted to have good bicep strength. The patient was noted to have undergone an injection at the subacromial bursa at that time. The clinical note dated 08/21/12 details the patient continuing with a snapping and popping at the left shoulder, specifically with range of motion activities. Pain was elicited with both forward flexion and overhead motions. Pain was elicited on both Neer and Hawkins maneuvers. The x-ray of the left shoulder dated 08/24/12 revealed an irregularity at the distal left clavicle, possibly due to a prior surgery. No evidence of acromioclavicular subluxation was noted. The clinical note dated 09/21/12 details the patient continuing with an audible snapping at the left shoulder with flexion and rotation. Pain was noted at the proximal biceps tendon. Jorgensen's test was noted to be positive as well as Speed's and O'Brien's tests. The patient was noted to have good biceps and rotator cuff strength. Pain was elicited with palpation over the AC joint resection site. The patient was provided with a second injection at that time. A therapy note dated 10/12/12 details the patient having completed 35 physical therapy sessions. The patient was able to demonstrate 135 degrees of left shoulder flexion, 124 degrees of abduction, and 68 degrees of external rotation. The clinical note dated 10/19/12 details the patient continuing with left shoulder deficits. The patient reported moderate relief following the previous injection which lasted 2 weeks. However, the pain was noted to return to baseline. A painful popping was noted at the anterior portion of the shoulders, specifically with flexion and rotation. Pain was elicited with palpation over the AC joint.

The utilization review dated 11/01/12 resulted in a denial secondary to a lack of updated imaging studies to include MR arthrogram revealing a specific labral tear.

The utilization review dated 11/09/12 also resulted in a denial secondary to a lack of documentation regarding the patient's updated MRI indicating significant 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 ongoing left shoulder pain with associated range of motion deficits despite a previous surgical intervention. The Official Disability Guidelines recommend debridement of the left shoulder provided the patient meets specific criteria to include imaging studies confirming the patient's significant pathology. There is a lack of updated imaging studies confirming the patient's labral pathology. The submitted x-ray of the left shoulder does confirm postoperative findings; however, there is a lack of information confirming the need for a surgical intervention. Given the lack of information regarding the patient's updated imaging studies confirming the patient's labral pathology, it is the opinion of the reviewer that this request for arthroscopy, shoulder, surgical; debridement, extensive does not meet guideline recommendations and is not medically necessary.

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)