

# Pure Resolutions LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:**

Jun/18/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Left shoulder scope with SAD and possible DCE

**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

Physical therapy report, undated

Handwritten clinical reports with illegible signature, dated 10/30/12 – 01/24/13

Radiographs of the left shoulder dated 11/02/12

MRI of the left shoulder dated 11/15/12

Clinical reports by Dr. dated 02/04/13 – 04/29/13

Prior reviews by Dr. & Dr. undated

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who initially sustained an injury on xx/xx/xx while lifting a student. The patient developed left shoulder pain. Initial imaging of the left shoulder completed in November of 2012 to include MRI studies on 11/15/12 were negative for any pathology. The patient has continued to report left shoulder pain despite physical therapy. The patient did receive an injection in February of 2013 which provided approximately 3 weeks of relief. Per the clinical evaluation on 04/01/13, the patient continued to have pain and tenderness to palpation over the acromioclavicular joint with positive Hawkins's sign for impingement. Surgical consult on 04/29/13 again indicated the patient did not reasonably improve with physical therapy, use of a sling, or injections. The patient did attend physical therapy for approximately 3 weeks through November of 2012. Physical examination demonstrated positive impingement signs in the left shoulder.

The request for a left shoulder arthroscopy to include subacromial decompression and a

possible distal clavicle excision was not recommended as medically necessary by utilization review. Per Dr. report, the patient had minimal pain and did not have significant pathology on imaging studies.

The request was again denied by utilization review where Dr. report indicated the patient did have a normal MRI of the left shoulder.

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

The patient has had persistent left shoulder pain despite conservative treatment that has included physical therapy and injections. The patient's exam findings did reveal positive impingement in the left shoulder; however, as the imaging of the left shoulder was normal per the 11/15/12 MRI studies, the requested subacromial decompression with possible distal clavicle excision would not meet current evidence based guidelines regarding shoulder interventions. Guidelines recommend that there should be clear pathology noted on MRI studies which are concordant with exam findings. Given the absence of any significant pathology on MRI studies of the left shoulder, the requested surgical procedures would not meet current evidence based guidelines and therefore, in this reviewer's opinion, are not medically necessary. As such, 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)