

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/23/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: OP RT shoulder scope, RCR, subscapular repair, labral repair, debride

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., 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. It is the opinion of this reviewer that the request for an OP RT shoulder scope, RCR, subscapular repair, labral repair, debride is not recommended as medically necessary

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
MRI of the right shoulder dated 09/05/12
Operative note dated 10/31/12
Functional capacity evaluation dated 05/14/12
Right shoulder arthrogram dated 06/14/13
Report of medical evaluation dated 08/22/13
Report of medical evaluation dated 04/24/13
Clinical note dated 09/13/12
Clinical note dated 10/11/12
Clinical note dated 11/16/12
Clinical note dated 11/20/12
Clinical note dated 12/11/12
Clinical note dated 01/08/13
Clinical note dated 03/21/13
Clinical note dated 04/18/13
Clinical note dated 05/16/13
Clinical note dated 06/13/13
Clinical note dated 06/25/13
Clinical note dated 08/01/13
Adverse determinations dated 08/22/13 & 09/19/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury regarding his right shoulder. The clinical note dated 09/13/12 indicates the patient stating the initial injury occurred when he was lifting and felt and heard a pop in the right shoulder. The patient stated the pain became intense. Upon exam, the patient was able to demonstrate

120 degrees of right shoulder flexion, 50 degrees of internal rotation, 90 degrees of abduction, and 70 degrees of external rotation. Strength deficits were also noted with flexion and external rotation that were rated as 4/5. The patient was recommended for physical therapy and was provided with a Cortisone injection at that time. The clinical note dated 10/11/12 indicates the patient continuing with the use of Celebrex, Tramadol, and Lortab for ongoing pain relief. The patient was noted to be undergoing activity limitations addressing the right shoulder complaints. The patient was further recommended for a right shoulder arthroscopy with an acromioplasty, distal clavicle excision, rotator cuff repair, subscapular repair, biceps tenodesis, and extensive debridement.

The operative report dated 10/31/12 indicates the patient undergoing a rotator cuff repair at the right shoulder along with a distal clavicle excision and acromioplasty. The clinical note dated 11/06/12 indicates the patient undergoing a home exercise program. The patient was noted to be utilizing a splint as well. The clinical note dated 02/08/13 indicates the patient complaining of neck pain as well as soreness at the right shoulder. The note mentions the patient utilizing Norco for ongoing pain relief. Range of motion and strength deficits continued at the right shoulder. The functional capacity evaluation dated 05/14/13 indicates the patient able to perform at a medium heavy physical demand level whereas the patient's occupation requires a very heavy physical demand level. The clinical note dated 05/16/13 indicates the patient undergoing a work strengthening program. However, the patient stated that he was unable to continue secondary to the amount of pain that he was experiencing. Range of motion and strength deficits continued at the right shoulder. The patient was provided with an injection at the subacromial space at that time. The right shoulder arthrogram dated 06/14/13 revealed post-surgical changes from a previous supraspinatus tendon repair. A recurrent high grade partial thickness tear was also noted. The distal superior subscapularis tendon was noted to have a partial thickness tear. Post-surgical changes were noted from a biceps tenodesis. Post-surgical changes were also noted regarding an acromioplasty and distal clavicle resection. The clinical note dated 08/01/13 indicates the patient continuing with right shoulder pain. The patient was recommended for a right shoulder revision involving an arthroscopic extensive debridement, loose body removal, rotator cuff repair revision, subscapularis repair, and a superior labral repair. The reported medical evaluation dated 08/22/13 indicates the patient having failed conservative therapy to include injections, medications, and multiple sessions of physical therapy.

The previous utilization review dated 08/22/13 resulted in a denial as no imaging studies confirmed the need for a labral repair.

The utilization review dated 09/19/13 resulted in a denial for a surgical intervention at the right shoulder as no imaging studies were submitted indicating the patient's labral tear.

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 right shoulder pain despite a previous surgical intervention. A labral repair would be indicated provided the patient meets specific criteria to include imaging studies confirming the patient's labral involvement. The submitted arthrogram of the right shoulder revealed rotator cuff involvement; however, no labral tear was noted. Therefore, the patient may benefit from a surgical procedure at the rotator cuff. However, given that no information was submitted regarding the patient's labral involvement, a surgical intervention would not be indicated as medically necessary. As such, it is the opinion of this reviewer that the request for an OP RT shoulder scope, RCR, subscapular repair, labral repair, debride is not recommended as 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)