

# US Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Aug/22/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** right shoulder scope, AC joint resection, subacromial decompression, RTC repair, poss labral repair, assistant doctor

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** D.O., Board Certified General 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 the request for right shoulder scope, AC joint resection, subacromial decompression, RTC repair, poss labral repair, assistant doctor is not recommended as medically necessary.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

ODG - Official Disability Guidelines & Treatment Guidelines  
Clinical notes 05/21/13-06/28/13  
MRI right shoulder 05/21/13  
Previous utilization review 07/01/13 and 07/09/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who reported an injury to his right shoulder. MRI of the right shoulder dated 05/21/13 revealed soft tissue edema with a partial tearing at the undersurface of the subscapularis. Mild granulation of the tissue was noted at the acromioclavicular joint. Mild tendinopathy was noted at the proximal aspect of the long head of the biceps. Degenerative findings were also noted at the glenoid labrum. Clinical note dated 05/22/13 detailed the patient complaining of increasing pain particularly at night. Clinical note dated 06/25/13 detailed the patient stating that the initial injury occurred when he was throwing cutters over a fence resulting in immediate onset of pain at the right shoulder. Upon exam the patient had a positive Neer and Hawkins exam. Tenderness to palpation was noted at anterolateral acromion and acromioclavicular joint and over the insertion points of the supraspinatus and subscapularis. The patient had range of motion limitations throughout the shoulder. The clinical note dated 06/20/13 detailed the patient being recommended for surgical intervention at the right shoulder. Previous utilization review dated 07/01/13 for right shoulder scope, acromioclavicular joint resection, subacromial decompression, rotator cuff repair, and labral possible labral repair with an assistant physician resulted in denial as no information was submitted regarding completion of an appropriate course of conservative treatment. Utilization review dated 07/09/13 for the surgical intervention at the right shoulder resulted in denial as no information was submitted regarding completion of a three month 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 right shoulder pain with associated range of motion deficits. Right arthroscopic joint resection with subacromial decompression and rotator cuff repair would be indicated provided that the patient meets specific criteria, including completion of all conservative measures. No information was submitted regarding previous involvement with conservative treatment addressing right shoulder complaints. Given this, the request is not indicated. As such it is the opinion of the reviewer that the request for right shoulder scope, AC joint resection, subacromial decompression, RTC repair, poss labral repair, assistant doctor 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)