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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Dec/11/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: left shoulder arthroscopy with rotator cuff debridement, possible repair, subacromial decompression and distal clavicle resection

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., 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 left shoulder arthroscopy with rotator cuff debridement, possible repair, subacromial decompression and distal clavicle resection is not medically necessary and the prior denials are upheld.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male with complaints of shoulder pain. On 10/07/14, an MRI of the left shoulder without contrast, revealed moderate osteoarthritic changes at the AC joint, causing compromise of the subacromial space. There is mild osteoarthritic changes of the glenohumeral joint with mild subcortical marrow edema in the superior lateral part of the humeral head. There was also a partial thickness tear in the supraspinatus tendon involving the anterior, mid and posterior fibers extending to the synovial surface and measuring 21mm in the AP dimension and 28mm along the length of the tendon fibers. There is mild fatty infiltration in the supraspinatus muscle. There was evidence of infraspinatus tendinosis, and there was subacromial/subdeltoid subscapularis bursitis. There was also mild subcutaneous edema in the superior lateral aspect of the shoulder. Exam was ready. On 10/16/14, this patient was seen in clinic and it was noted he had undergone treatment with activity modification, NSAIDs, and pain management with steroids and therapy. Pain to his shoulder at rest was 8/10 with more pain with overhead reaching activity. Physical examination of his left shoulder revealed tenderness at the AC joint, tenderness at the anterior and lateral aspect of the left shoulder joint with forward elevation at 100 degrees abduction at 90 degrees, external rotation at 60 degrees and internal rotation was to L5. He did have positive impingement sign, positive O'Brien's test, positive Yergason's test, positive Speed's test, and sensation was intact. He had no pain to the bilateral elbows, wrists, or hands, and he had full range of motion to those joints. Left shoulder arthroscopy with rotator cuff debridement, possible repair, subacromial decompression, and a distal clavicle resection was recommended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On 10/28/14, a peer clinical review report was submitted for this requested service. It was noted that based on Official Disability Guidelines, the surgery would not be indicated. While it was noted that the patient was unable to have steroid injections due to an allergy, he has still not completed 3-6 months of conservative care that would be warranted before proceeding with operative procedures for partial thickness rotator cuff tear or impingement. It was also noted that given his time frame from injury was less than 2 months, he had failed to satisfy guideline criteria that would support 3-6 months of measures in a conservative fashion before surgical intervention. On 11/12/14, an appeal utilization review determination was that the information submitted for review fails to meet the evidence based guidelines for the requested service. It was noted the records submitted for review indicate the patient had attended 9 visits of physical therapy from 09/11/14 – 09/09/14 possibly an error. The records do not document 3-6 months of conservative care and therefore the request was non-certified. The records submitted for this review indicates the physical therapy history and physical was performed on 09/11/14. The last physical therapy note was dated 10/09/14. Therefore, there has been failure to document 3-6 months of conservative care as recommended by guidelines for a partial rotator cuff tear or for impingement. As such it is the opinion of this reviewer that the request for left shoulder arthroscopy with rotator cuff debridement, possible repair, subacromial decompression and distal clavicle resection is not medically necessary and 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)