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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Aug/01/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Arthroscopy with Rotator Cuff Tear Repair, SLAP (Glenoid Labrum) Lesion Tendon Repair, Debridement, Acromioclavicular Joint Resection with Platelet Rich Plasma with Fat Graft and Bone Marrow Aspirate for the Left Shoulder as Outpatient.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified Orthopedic Surgeon

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male whose date of injury is xx/xx/xx. The mechanism of injury is not described, but the claimant is noted to complain of left shoulder pain and limited range of motion. Left shoulder MRI dated 01/23/14 revealed tearing of the anterior and posterior labrum with predominant component involving the posterior labrum extending inferiorly; no clear displaced labral fragment; small paralabral cyst with a multiloculated component which extends along the posterior margin of the glenoid. There is low grade articular and bursal tearing of the supraspinatus and infraspinatus tendons; no full thickness tear. Mild degenerative changes of the AC joint also were noted. The claimant was seen on 04/28/14 for initial physical therapy evaluation and was recommended for physical therapy 3 x a week for 4 weeks. No subsequent physical therapy progress notes were provided. The claimant was for orthopedic evaluation on 05/29/14. On examination of the left shoulder there was pain and tenderness of the anterolateral supraspinatus tendon; pain in the thumb down position against resistance; positive Neer and Hawkins signs. A request for left shoulder arthroscopy with rotator cuff repair; SLAP lesion repair; debridement; AC joint resection with platelet rich plasma with fat graft and bone marrow aspirate was reviewed on 06/16/14. The request was non-certified, noting that treatment guidelines require failure of at least 3-6 months of conservative treatment with physical therapy, anti-inflammatory medications, and injections prior to surgical intervention for partial thickness rotator cuff tear. The claimant is noted to have had some physical therapy for the back and neck, but there is no indication that any significant physical therapy has been accomplished for the left shoulder, nor is there

documentation of NSAIDs or injection of the left shoulder. It was further noted that physical examination findings were not markedly positive for significant labral pathology. The request included platelet rich plasma as well as fat graft and bone marrow aspiration, which are not supported by treatment guidelines. A reconsideration request was reviewed and non-certified on 06/26/14, noting the lack of documentation of appropriate conservative treatment prior to surgical intervention and the lack of guideline support for platelet rich plasma, fat graft and bone marrow aspirate. The reviewer noted that the only physical therapy notes submitted for review consisted of the initial physical therapy evaluation dated 04/28/14 which documented fairly symmetric range of motion of the bilateral shoulders and symmetric strength in the bilateral upper extremities graded primarily 3/5 bilaterally.

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

The claimant reportedly injured his left shoulder on xx/xx/xx due to unknown mechanism of injury. MRI of the left shoulder revealed a partial thickness rotator cuff tear; tearing of the anterior and posterior labrum with no clear displaced labral fragment; and mild degenerative changes of the AC joint. There is no documentation submitted for review demonstrating the nature and extent of conservative measures completed to date directed to the left shoulder. No physical therapy daily progress reports were submitted documenting the total number of physical therapy visits have been completed, modalities used, and response to treatment. There is no indication that the claimant has had a trial of anti-inflammatory medications or injection of the left shoulder. The request for the use of platelet rich plasma with fat graft and bone marrow aspirate is not supported by current evidence-based guidelines. Based on the clinical information provided, it is this reviewer's opinion that medical necessity is not established for left shoulder arthroscopy with rotator cuff repair; SLAP lesion repair; debridement; AC joint resection with platelet rich plasma with fat graft and bone marrow aspirate. The previous denials were correctly determined and should be upheld on IRO.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES