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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Dec/27/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

O/P Right Shoulder Arthroscopy w/Subacromial Debridement

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

MRI right shoulder 04/04/12

Surgical report 05/09/12

Designated doctor evaluation 08/07/13

MRI right shoulder 07/13/12

Clinical notes 03/28/12

Clinical notes 04/11/12

Clinical notes 04/25/12

Clinical notes 05/17/12

Clinical notes 05/21/12

Clinical notes 07/26/12

Clinical notes 09/27/12

Surgery surgical note 10/10/12

Clinical notes 10/25/12

Clinical notes 11/27/12

Clinical notes 12/20/12

Clinical notes 01/18/13

Clinical notes 01/25/13

Clinical notes 02/26/13

Clinical notes 04/25/13

Clinical notes 06/25/13

Letter of appeal 09/03/13
Clinical notes 09/04/13
Clinical notes 09/25/13
Clinical notes 09/26/13
Clinical notes 10/31/13
Clinical notes 12/05/13
Clinical notes 03/21/12
Adverse determinations 11/04/13 and 12/02/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury to his right shoulder. Clinical note dated 03/21/12 indicated the patient presenting with right shoulder complaints. The patient stated he was experiencing severe pain over the shoulder and limited range of motion. Upon exam joint stiffness was noted throughout the right shoulder. Range of motion was decreased with flexion, extension, adduction, abduction, internal, and external rotation. The patient utilized cyclobenzaprine and diclofenac for ongoing pain relief. The clinical note dated 03/28/12 indicated the patient stating the initial injury occurred prior to the office visit. The patient utilized hydrocodone at this time. Decreased range of motion continued throughout the right shoulder. MRI of the right shoulder dated 07/13/12 revealed a partial thickness tear of the supraspinatus tendon near the myotendinous junction. Grade 1 superior anterior labral tear was also noted. Operative report dated 10/10/12 indicated the patient undergoing arthroscopic subacromial decompression at the right shoulder. Clinical note dated 10/25/13 indicated the patient presenting for follow up visit. The patient continued with complaints of pain despite ongoing use of medications. The patient initiated physical therapy at this time. Range of motion continued to be decreased throughout the shoulder. Clinical note dated 11/27/12 indicated the patient continuing with ongoing right shoulder pain with associated range of motion limitations. Clinical note dated 12/20/12 indicated the patient planning to return to work on 01/07/13. Clinical note dated 04/29/13 indicated the patient having 3/5 strength with right shoulder adduction. Pain was elicited with extension and abduction as well. Clinical note dated 06/25/13 mentioned the patient continuing with physical therapy. Pain radiated from the shoulder to the hand. Clinical note dated 09/26/13 mentioned the patient rating his right shoulder pain as 3-7/10. Tenderness to palpation was noted at the right shoulder joint at the acromioclavicular joint. The patient had slightly positive impingement signs. The patient demonstrated 110 degrees of right shoulder flexion, 45 degrees of extension, 100 degrees of abduction, and 25 degrees of adduction. Range of motion limitations were further noted including 45 degrees of internal rotation and 50 degrees of external rotation. Strength deficits were noted with flexion, abduction, and external rotation. Clinical note dated 10/31/13 mentioned the patient continuing with the use of hydrocodone. Clinical note dated 12/05/13 mentioned the patient continuing with right shoulder pain. Utilization review dated 11/04/13 resulted in denial for right shoulder surgery as no documentation was submitted confirming injection therapy. No updated imaging studies were submitted as well. Utilization review dated 12/02/13 resulted in denial for a surgical intervention at the right shoulder as no recent imaging studies were submitted confirming clinical findings.

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 continuing with right shoulder pain and range of motion limitations despite previous surgical intervention. Arthroscopic subacromial debridement would be indicated provided that the patient meets specific criteria, including imaging updated imaging studies confirming pathology. No recent imaging studies were submitted including any post-operative findings regarding the need for surgical intervention for this patient at this time. Given these findings, it is the opinion of this reviewer that the request right shoulder arthroscopy with debridement at the right shoulder 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)