

True Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

May/27/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Op Polar Care Unit-Right Shoulder

Right Shoulder Scope, Rotator Cuff Repair, Subacromial Decompression

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported an injury to her right shoulder. The clinical note dated xxxxx indicates the patient complaining of gradually worsening pain at the right shoulder specifically at the anterior region. The patient rated the pain as 7/10. Radiating pain was also identified down into the right arm. Upon exam, tenderness was identified upon palpation. The patient was able to demonstrate 90 degrees of abduction at that time. The patient was recommended for physical therapy as well as the use of Naproxen for pain relief. The clinical note dated 12/03/13 indicates the patient having initiated physical therapy to address the right shoulder issues. The patient had been working with duty restrictions in place. The patient stated that the use of medications was providing some relief. The clinical note dated 01/30/14 indicates the patient complaining of intermittent exacerbations of pain throughout the right shoulder. The patient demonstrated decreased range of motion in all planes. Pain was elicited during the testing in all planes as well. The therapy note dated 02/03/14 indicates the patient having completed 5 physical therapy sessions to date. The clinical note dated 02/03/14 indicates the patient stating that she felt some slow improvements with the right shoulder. The clinical note dated 02/11/14 indicates the patient able to demonstrate 120 degrees of abduction and 90 degrees of flexion. The note indicates the patient utilizing Ultram for pain relief. The clinical note dated 02/20/14 indicates the

patient having completed an additional 2 sessions of physical therapy at that time. The patient was working light duty. The MRI of the right shoulder dated 03/03/14 revealed a full thickness tear of the distal supraspinatus tendon. A 15% thickness intrasubstance tear was also identified at the distal infraspinatus. Glenohumeral joint effusion and subacromial subdeltoid bursal fluid collection was also identified. Impingement was also revealed. The clinical note dated 03/05/14 indicates the patient complaining of worsening pain with reaching for objects. The patient also stated that internal rotation exacerbated her pain level. The designated doctor evaluation dated 04/08/14 indicates the patient continuing with right shoulder pain. The note indicates the patient having completed a course of conservative treatments to include physical therapy and chiropractic manipulation.

The utilization review dated 03/24/14 resulted in a denial as no documentation had been submitted regarding a failure of conservative treatments.

The utilization review dated 04/28/14 indicates the patient having been denied a surgical procedure at the right shoulder as no significant deficits were identified.

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

The documentation indicates the patient complaining of right shoulder pain with associated range of motion deficits. An arthroscopic rotator cuff repair with a subacromial decompression is indicated for patients with significant symptomology identified by clinical exam and imaging studies confirm the patient's pathology. The most recent clinical exam indicates the patient demonstrating range of motion and strength deficits throughout the right shoulder. The submitted MRI revealed a full thickness tear of the supraspinatus and a partial tear of the infraspinatus as well as signs of impingement. Given the significant pathology confirmed by imaging studies and taking into account the ongoing functional deficits associated with the rotator cuff involvement, this request is reasonable. As such, it is the opinion of this reviewer that the request for a right shoulder scope/rotator cuff repair and subacromial decompression is recommended as medically necessary.

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