

# I-Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jun/12/2014

IRO CASE #:

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** right shoulder arthroscopy, subacromial decompression, lateral debridement, distal clavicle resection, possible biceps tenodesis, possible rotator cuff repair

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., 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.** It is the opinion of this reviewer that the request for right shoulder arthroscopy, subacromial decompression, lateral debridement, distal clavicle resection, possible biceps tenodesis, possible rotator cuff repair is not recommended as medically necessary.

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

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male who reported an injury to his right shoulder on xx/xx/xx. The MRI of the right shoulder dated xxxxxx revealed partial surf bursal surface tear of the supraspinatus and SLAP tear. Long head of the biceps tendon was identified as being intact. A clinical note dated 02/26/14 indicated the patient complaining of right shoulder pain rated 6/10. The patient stated the patient was occasionally interfering with his activities of daily living. Reaching up and out, lifting objects and overhead activities all exacerbated the pain. The patient previously underwent physical therapy with no significant improvement. Upon exam the patient demonstrated 40 degrees of flexion, 45 degrees of abduction, and 10 degrees of external rotation. Weakness was significant weakness was identified throughout the shoulder. A clinical note dated 03/05/14 indicated the patient continuing with right shoulder pain located at the anterior and lateral shoulder. The patient underwent subacromial injection which provided two to three days of relief. The patient was recommended for Duexis for pain relief. The patient underwent home exercise program. A clinical note dated 05/14/14 indicated the patient continuing with 6/10 pain at the right shoulder. The patient stated the shoulder felt as if something was wedged into it. The patient demonstrated 60 degrees of right shoulder flexion and 45 degrees of abduction. Upon exam the patient demonstrated positive Neer and Hawkins signs. A clinical note dated 05/22/14 indicated the patient sleeping affected by shoulder pain. The patient stated he was frequently awake when rolling on to that side. Previous utilization review dated 04/02/14 resulted in denial as no significant pathology was identified within the acromioclavicular joint indicating medical necessity for distal clavicle resection. A clinic utilization review dated 05/12/14 resulted in denial as no subjective complaints of pain were identified within the rotator cuff.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The request for Right shoulder arthroscopy, subacromial decompression, lateral debridement, distal clavicle resection, possible biceps tenodesis, and possible rotator cuff repair is non-certified. Clinical documentation indicates the patient having supraspinatus tear and SLAP tear confirmed by recent MRI. The patient underwent course of physical therapy and injections at the right shoulder. Therefore, the patient may benefit from a rotator cuff repair and subacromial decompression. However the MRI also revealed long head of the biceps tendon being intact. No other findings were identified. Therefore, it is unclear if the patient would benefit from a biceps tenodesis. Given this, the requested procedure is not indicated. As such, it is the opinion of this reviewer that the request for right shoulder arthroscopy, subacromial decompression, lateral debridement, distal clavicle resection, possible biceps tenodesis, possible rotator cuff repair 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)