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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: May/19/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: left shoulder SAD, rotator cuff repair vs. debridement/extensive debridement/synovectomy/TAI, shoulder orthosis, cryorental x 7 days, 23 hours observation stay, surgical assistant, abduction brace - purchase

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., 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 a left shoulder SAD, rotator cuff repair vs. debridement/extensive debridement/synovectomy/TAI, shoulder orthosis, cryorental x 7 days, 23 hours observation stay, surgical assistant, abduction brace - purchase is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who reported an injury to her left shoulder. The patient stated she had been grabbed suddenly resulting in sharp pain in the left shoulder. A clinical note dated xxxx indicated the patient rating her left shoulder pain as 6/10. The patient stated she was having difficulty sleeping secondary to ongoing pain. The patient described the pain as a dull ache located at the inferior region of the humeral head. Pain radiated into the left upper extremity. Upon exam the patient demonstrated 125 degrees of left shoulder flexion, 30 degrees of extension, and 75 degrees of abduction. 4/5 strength was identified throughout the shoulder. Moderate tenderness was identified at the left upper trapezius and glenohumeral joint. A clinical note dated 01/28/14 indicated the patient describing a constant burning sensation along with a popping. The patient rated the pain as 7/10. The patient initiated physical therapy. The MRI of the left shoulder dated 02/06/14 revealed evidence of adhesive capsulitis. A very small partial tear was identified at the rotator cuff. Small posterior possible posterior labral tear was also revealed. A clinical note dated 02/19/14 indicated the patient continuing with left shoulder pain described as an aching, burning, and sharp sensation. The patient stated that the current use of medications was not providing any significant benefit. The patient reported additional popping at this time. The patient utilized tramadol, Flexeril, and Anaprox.

A clinical note dated xxxx indicated the patient describing her left shoulder pain as a deep throbbing sensation. Previous physical therapy provided some benefit.

The utilization review dated 04/17/14 indicated the request resulting in a denial as no information was submitted confirming a three month course of conservative treatment. Additionally the imaging revealed only a small partial rotator cuff tear and no definitive evidence of a labral tear.

The utilization review dated 04/23/14 resulted in a denial as no additional documentation had been provided confirming completion of all conservative treatment.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The clinical documentation indicated the patient complaining of left shoulder pain with associated range of motion deficits. A rotator cuff repair and subacromial decompression would be indicated provided that the patient meets specific criteria, including completion of all conservative treatment and imaging evidence confirms significant pathology. The MRI revealed a small rotator cuff tear. There is also a possibility of labral involvement. However, no full thickness tear was identified at the rotator cuff. Additionally, no definitive evidence was provided confirming the labral tear. There is an indication the patient has undergone some physical therapy. However no therapy notes were submitted confirming a three month course of treatment. No information was submitted regarding previous injection therapy at the left shoulder. Given these factors, the request is not indicated. Additionally, as the surgery is not fully indicated, the additional requests for a shoulder orthosis, cryo rental times seven days, 23 hour observational stay with a surgical assistant and abduction brace are not indicated. As such, it is the opinion of this reviewer that the request for a left shoulder SAD, rotator cuff repair vs. debridement/extensive debridement/synovectomy/TAI, shoulder orthosis, cryorental x 7 days, 23 hours observation stay, surgical assistant, abduction brace - purchase 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)