

Becket Systems

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DATE NOTICE SENT TO ALL PARTIES: Jun/29/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: right shoulder arthro distal clavicle between XX/XX/XX XX/XX/XX; right shoulder slap repair between XXX/XX/XX XX/XX/XX

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: DO, 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 this reviewer's opinion that medical necessity for the right shoulder arthro distal clavicle between XX/XX/XX-XX/XX/XX; right shoulder slap repair between XX/XX/XX-XX/XX/XX has not been established.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who was injured on XX/XX/XX. The patient has been followed for complaints of right shoulder pain due to repetitive XX work. The patient had persistent right shoulder pain despite physical therapy and medications to include anti-inflammatories. The patient underwent subacromial as well as acromioclavicular joint injections which provided approximately 50% improvement. MRI studies of the right shoulder from X/XX/XX noted no evidence of a SLAP tear superiorly. There was a chronic bank hurt Bankart type tear with underlying cystic changes. There was a high grade incomplete tear of the supraspinatus tendon involving more than 80% of the tendon width. No significant changes at the acromioclavicular joint were evident. The patient was followed by XX. The X/XX/XX evaluation noted limited range of motion in the right shoulder on forward elevation and external rotation. There was some mild weakness noted at the supraspinatus and infraspinatus. There was diffuse tenderness within the acromioclavicular joint. There was a negative O'Brien and Speed sign. Plain film radiographs were reported to show degenerative changes in the acromion. The requested SLAP repair and distal clavicle excision were denied by utilization review as there was no evidence of substantial post-traumatic arthritis or severe degenerative changes in the acromioclavicular joint. There was also no imaging evidence consistent with symptomatic SLAP tear.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient presents with persistent right shoulder complaints despite conservative management to include physical therapy, medications, and injections. MRI studies did not identify evidence of any significant acromioclavicular joint osteoarthritis. There was no clear labral tear evident. The study was a non-contrasted MRI of the right shoulder. The patient's physical examination findings did not clearly indicate either a symptomatic SLAP tear or any substantial pain originating from the acromioclavicular joint. Given the minimal evidence

provided for review that would meet guideline recommendations for the requested services, it is this reviewer's opinion that medical necessity for the right shoulder arthro distal clavicle between XX/XX/XX-XX/XX/XX; right shoulder slap repair between XX/XX/XX-XX/XX/XX has not been established and the prior denials are upheld.

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)