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DATE NOTICE SENT TO ALL PARTIES: May/18/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Right shoulder arthroscopy, rotator cuff repair, subacromial decompression and biceps tenodesis, as an outpatient

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 medically necessity for the right shoulder arthroscopy, rotator cuff repair, subacromial decompression and biceps tenodesis, as an outpatient has not been established.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who was injured on XX/XX/XX. The patient was followed for complaints of right shoulder pain posteriorly and in the biceps region. The patient endorsed weakness and limited range of motion of the right shoulder. No prior treatment was documented. MRI studies of the right shoulder from XX/XX/XX did note a superior labral tear seen extending anterior to posterior with extension to the anterior superior labrum. There was a full thickness and focal tear of the distal insertional fibers and supraspinatus tendon with high grade partial thickness tearing elsewhere within the tendon. Thickening of the infraspinatus tendon was noted with low grade interstitial tearing. Atrophy was present at the teres minor with attenuation of the tendon. Interstitial tearing was also present at the subscapularis. The XX/XX/XX clinical report noted tenderness over the right subacromial space with painful range of motion. There was intact strength with a positive empty can and impingement signs. Due to the extent of the rotator cuff tear, surgery was recommended. The surgical request was denied by utilization review as there was no indication that conservative management had failed. There was also no significant loss of range of motion identified in the records.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The clinical documentation provided for review did note ongoing right shoulder pain. There was no documented conservative management evident in the records. The patient did have MRI studies of the right shoulder which noted ulnar appearing rotator cuff tears at the teres minor with a full thickness tear of the supraspinatus tendon. The patient's physical exam did note positive impingement signs; however, there was no evidence of motor weakness or significant loss of range of motion. Given the fairly limited physical exam findings, it is still unclear how the patient's function would be reasonably improved with surgical intervention. There was also no documentation regarding conservative management to support proceeding with subacromial decompression or a biceps tenodesis procedure. Due to the above noted concerns, it is this reviewer's opinion that medically necessity for the right shoulder arthroscopy, rotator cuff repair,

subacromial decompression and biceps tenodesis, as an outpatient has not been established. Therefore, the prior denials remain 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)