

Clear Resolutions Inc.

An Independent Review Organization

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DATE NOTICE SENT TO ALL PARTIES: Feb/26/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Left shoulder scope, rotator cuff repair, bicep tenodesis, subacromial decompression, and distal clavicle resection

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, 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 request of Left shoulder scope, rotator cuff repair, bicep tenodesis, subacromial decompression, and distal clavicle resection has not been established

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who was injured on XX/XX/XX when she slipped and fell injuring the left shoulder. The patient was initially treated with physical therapy. The patient was prescribed anti-inflammatories in XXXX. The patient had one subacromial injection to the left shoulder completed on XX/XX/XX. Of the exact response to the subacromial injection was not documented. The patient was referred back to physical therapy in XX/XXXX. There is a gap in the clinical treatment. The patient returned in XX/XXXX complaining of persistent pain the left shoulder that had become more severe. The patient was recommended to return to physical therapy and obtain additional injections. The records did not include any further indication regarding physical therapy or injections. The patient had a MR arthrogram study of the left shoulder which noted no significant osteoarthritis in the acromioclavicular joint. The rotator cuff found or appeared to be normal. The biceps also appeared to be normal. There was a focal area of increased signal within the small cleft extending into the superior labrum without a disparate displaced labral tear. The patient was seen for follow up on XX/XX/XX. The physical examination noted limited range of motion the left shoulder on external rotation and forward flexion. There was also severe pain with internal rotation and resisted abduction. The patient had positive cross arm testing as well as pain with Speed and O'Brien compression testing. The requested surgical procedures to include rotator cuff repair, biceps tenodesis, subacromial decompression, and distal clavicle resection was denied by utilization review as the prior reviewer did not feel that there was any imaging evidence pathology to the extent that it would require surgical intervention.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has been followed for a history of left shoulder pain. There was a gap in clinical treatment from XXXX-XXXX. The patient reported increasing levels of left shoulder pain. The records did not include any recent conservative management although this was recommended by the treating physician. There was no documentation regarding recent physical therapy or injections. Furthermore,

the recent MR arthrogram study the left shoulder failed to identify any significant pathology that would require any of the requested surgical procedures. There was no evidence of any substantial tearing of the rotator cuff or biceps tendon any evidence of acromioclavicular osteoarthritis contributing to ago impingement of the subacromial outlet. Although there are physical examination findings suggesting underlying pathology, these do not correlate with imaging. Therefore, it is this reviewer's opinion that medical necessity for the request of Left shoulder scope, rotator cuff repair, bicep tenodesis, subacromial decompression, and distal clavicle resection has not been established and 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)