

Clear Resolutions Inc.

An Independent Review Organization

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DATE NOTICE SENT TO ALL PARTIES: May/05/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: arthroscopic acromioplasty of R shoulder

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 opinion of this reviewer that the request for arthroscopic acromioplasty of R shoulder is not medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female. On XX/XX/XX, a MRI of the right shoulder was obtained revealing mild spurring and edema long the acromioclavicular joint, with a type 2 acromion, with mild subacromial space narrowing. There was also mild subacromial such subdeltoid bursitis, and there was no rotator cuff tear. On XX/XX/XX, the patient was seen in clinic. She had pain and tenderness to the anterior acromial region, with weakness in abduction and forward flexion and limited range of motion in abduction at 90-120 degrees. There was negative apprehension sign. She reported continued night pain.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On XX/XX/XX, a peer review report was submitted for the requested arthroscopic acromioplasty the right shoulder, and noted the patient had limited physical therapy. There was less than three months of attempted conservative care. Therefore the request did not meet guideline criteria and was non-certified.

On XX/XX/XX, a utilization review reconsideration for the arthroscopic acromioplasty of the right shoulder, stated the patient had not exhausted three months of continuous or six months intermittent rehabilitation directed to the shoulder for regaining strength and range of motion deficits as recommended by the guidelines and therefore the request was non-certified.

The guidelines recommend 3 to 6 months conservative therapy to the shoulder prior to an acromioplasty. The records do not indicate the patient has attempted 3 months of consecutive therapy to the right shoulder

It is opinion of this reviewer that the request for arthroscopic acromioplasty of R shoulder is not medically necessary 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)