Clear Resolutions Inc.

An Independent Review Organization
6800 W. Gate Blvd., #132-323
Austin, TX 78745
Phone: (512) 879-6370
Fax: (512) 572-0836
Email: resolutions.manager@cri-iro.com

Description of the service or services in dispute:
Arthroscopic subacromial decompression and debridement of the right shoulder

Description of the qualifications for each physician or other health care provider who reviewed the decision:
Board Certified Orthopedic Surgeon

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Overturned (Disagree)
- ☐ Upheld (Agree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XXXX is a XXXX who was diagnosed with impingement syndrome of the right shoulder.

On XXX, the patient was XXXXX, as XXXX was XXXX. As XXXX fell backward and XXXX, XXXX landed on XXXX right outstretched hand and that had caused XXXX to have pain in XXXX right shoulder region. XXXX had little soreness in the wrist but no pain in the hand, wrist or elbow regions. XXXX had pain in the right shoulder region.

On XXXX, XXXX was evaluated by XXXX, for right shoulder pain. XXXX reported temporary relief with the corticosteroid injection. The pain was moderate and aching in nature. On physical examination, the active range of motion of the right shoulder region was 0 degrees external rotation and 90 degrees abduction and internal rotation. The active range of motion of the left shoulder region was 0 degrees external rotation and 90 degrees abduction. The passive range of motion at the right shoulder region was 0 degrees external rotation, 120 degrees forward flexion and 90 degrees abduction and external rotation. The passive range of motion of the left shoulder region was 0 degrees external rotation and 90 degrees abduction. Hawkins' test and Neer's test were positive on the right.

Treatment to date consisted of Mobic (beneficial), corticosteroid injection, and physical therapy.

An MRI arthogram of the right shoulder dated XXXX showed fraying of the superior labrum with suggestion of possible small superior labral anterior posterior (SLAP) lesion with mild tendinosis involving the suprahumeral rotator cuff tendons and biceps tendon with no significant tear identified. There were moderate degenerative changes at the acromioclavicular joint with mild bone marrow edema in the distal clavicle region.

Per a utilization review determination letter dated XXXX, by XXX, the request for arthroscopic subacromial decompression and debridement of the right shoulder was denied. Per note, the guideline would not support surgery without objective documentation of trial and failure of nonoperative treatment. Exhaustion of three to six months of nonoperative treatment as recommended by the guidelines was not provided.

Per a utilization review dated XXX by XXXX, the reconsideration request for arthroscopic subacromial decompression and debridement of the right shoulder was denied. Per note, the guideline recommended three to six months of conservative care prior to the recommended surgery. The patient was noted to have participated in physical therapy and was given a steroid injection with only temporary relief of symptoms. However, the documentation lacked the recommended subjective complaints of pain with active arc motion 90 to 130 degrees and pain at night. Additionally, the records lacked documentation of the recommended objective findings to include weak or absent abduction and tenderness over the rotator cuff or anterior acromial area.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The previous denial of the arthroscopic subacromial decompression and debridement should be overturned. The documentation available very clearly indicates positive signs of impingement on examination and diminished forward flexion secondary to pain with a positive Hawkins and Neer's test. The symptoms have been present now for approximately XXXX with documented failure of conservative measures including oral NSAIDs, subacromial corticosteroid injections, and physical therapy. Findings on imaging are also consistent with shoulder impingement. It is highly unlikely that further conservative measures will result in any additional objective functional improvement given the failure of prior treatment. The requested operative intervention is considered medically necessary, and overturning the prior denials is advised.

A description and the source of the screening criteria or other clinical basis used to make the decision:

☐ ACOEM-America College of Occupational and Environmental Medicine um knowledgebase

☐ AHRQ-Agency for Healthcare Research and Quality Guidelines DWC-Division of Workers

☐ Compensation Policies and Guidelines European Guidelines for Management of Chronic Low Back Pain

☐ Interqual Criteria

☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards

☐ Mercy Center Consensus Conference Guidelines

☐ Milliman Care Guidelines

☑ ODG-Official Disability Guidelines and Treatment Guidelines

- Shoulder Chapter-Surgery

☐ Pressley Reed, the Medical Disability Advisor

☐ Texas Guidelines for Chiropractic Quality Assurance and 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)