Pure Resolutions LLC

Notice of Independent Review Decision

Case Number: XXXX Date of Notice: 5/14/2018 8:47:02 PM CST

Pure Resolutions LLC

An Independent Review Organization
990 Hwy 287 N. Ste. 106 PMB 133
Mansfield, TX 76063
Phone: (817) 779-3288
Fax: (888) 511-3176
Email: brittany@pureresolutions.com

IRO REVIEWER REPORT

Date: 5/14/2018 8:47:02 PM CST
Amended Date: 5/26/2018

IRO CASE #: XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Right shoulder arthroscopy, subacromial decompression, distal clavicle excision, rotator cuff repair and Right Shoulder Post-Op Brace

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Orthopaedic Surgery

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Overturned	Disagree
☐ Partially Overtuned	Agree in part/Disagree in part
☐ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]:
This case involves a now XX with a history of an occupational claim from XX. XX was injured when XX on XX right shoulder. The patient was diagnosed with impingement syndrome of the right shoulder, strain of neck muscle, strain of the right elbow, sprain of the lumbar region, and close fracture of one rib of the right side with routine healing. MRI of the right shoulder performed on XXXX revealed mild supraspinatus and infraspinatus tendinosis with articular sided fraying, punctate degenerative interstitial tearing at the footplate of the anterior infraspinatus tendon, mild superior subscapularis tendinosis, cartilage thinning and osteophyte formation throughout the glenohumeral joint, consistent with moderate osteoarthritis, mild subdeltoid and subacromial bursitis, degenerative fraying of the anterior superior and posterior superior labrum, volume loss within the acromion with widening of the acromioclavicular interval, extra-articular biceps tendon sheath tenosynovitis, and a large multi-loculated ganglion cyst along the lateral aspect of the biceps tendon sheath. On XXXX, the patient reported ongoing pain with overhead activity. Prior treatment included physical therapy, with no significant relief. On physical examination of the right shoulder, forward elevation was 155°, external rotation was 50°, and internal rotation was to L5. Impingement sign and cross arm abduction were positive. There was tenderness to palpation over the acromial clavicular joint region and biceps tendon. The provider noted that a corticosteroid injection for the shoulder was

contraindicated, and the patient had been hurting for greater than XX since the date of injury despite conservative care. The request was submitted for right shoulder arthroscopy with subacromial decompression, distal clavicle excision, and rotator cuff repair. However, this request was previously denied given that the patient did not have a corticosteroid injection, and there was no clear rationale on why the injection was contraindicated. Additionally, the physical therapy reevaluation did not state that the patient had physical therapy specific to the right shoulder. The patient was then evaluated on XX with persistent pain. Examination revealed persistent functional deficits. The provider noted that surgery had previously been denied because XX did not have physical therapy, although the provider noted that physical therapy for the shoulder had been documented. XX continued to have mechanical symptoms, especially with overhead activity. Patient also reported catching with lateral movements. The physical therapy was documented to have been targeted at the right shoulder, although this actually increased XX symptomatology given the findings of full-thickness tear. Regarding the injection, the provider noted a risk for more severe injury, as the cortisone would decrease the patient's discomfort and increase the risk for damage with movement, given the specific type of injury. The request was submitted for an appeal.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Regarding the requested surgical procedure, the available documentation indicated that surgery was previously denied due to unclear documentation regarding prior conservative care directed specifically at the right shoulder, and no evidence of a prior corticosteroid injection. Additional documentation was provided for review confirming that the patient had failed conservative care directed at the right shoulder, and the provider addressed the rationale for not performing a steroid injection. The Official Disability Guidelines require a diagnostic anesthetic injection prior to surgery for impingement and prior to partial claviculectomy. The provider noted that this was contraindicated based on an increased risk for reinjury. Given this particular clinical circumstance, and the patient's failure of multiple other modalities of treatment, proceeding with surgery is supported and reasonable to address the patient's persistent pain and functional deficits.

Therefore, the prior determination is overturned, and right shoulder arthroscopy, subacromial decompression, distal clavicle excision, rotator cuff repair and Right Shoulder Post-Op Brace is medically necessary.

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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL

Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, Shoulder, Surgery for impingement syndrome and ODG Indications for Surgery™ -- Bursectomy/Debridement and/or Acromioplasty: