True Decisions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

Case Number: ***Date of Notice:*** 04/03/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

1. Outpatient right shoulder arthroscopy with SAD, DCR, and RCR
2. 6 sessions of post op physical therapy

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)

Patient Clinical History (Summary)

This patient is a female with complaints of right shoulder pain. On xx/xx/xx, an MRI of the right shoulder revealed abnormal signal involving the superficial fibers of the distal subscapularis tendon consistent with intrasubstance injury and/or partial tear. The biceps tendon was intact. There was mild degenerative change to the AC joint and the labrum demonstrated absence of joint fluid limiting the evaluation but there were no gross labral abnormalities identified. On 01/28/15, the patient was seen in clinic. Right shoulder exam revealed rotator cuff strength testing of the supraspinatus rated at 4/5. Shoulder apprehension sign was negative. The patient had a positive impingement test to the shoulder which was moderate. Active ranges of motion were mildly restricted.

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

On 02/04/15, a utilization review determination letter stated the request for a right shoulder arthroscopy, outpatient with 6 sessions of physical therapy for post-op care, was not medically necessary. In regards to the rationale, it was noted there was no documentation of at least 3-6 months of conservative care treatment or objective clinical findings such as positive impingement test that would warrant the need for surgery. There was no documentation of at least 6 weeks of conservative care treatment or objective clinical findings such as tenderness over the AC joint, and as the requested surgery was not supported, the 6 sessions of postoperative physical therapy would not be supported. On 02/16/15, a review for an adverse determination was submitted noting that no additional medical records had been provided. The treating provider described that it had been 6 months since the date of injury and an injection had been given into the subacromial space on 01/14/15. A follow up report of 01/28/15 described 3 days of relief. It was noted there has not been 3-6 months of conservative treatment without documentation of any therapy. Therefore the request was non-certified.

Guidelines indicate that for a rotator cuff repair that is partial in nature, the should be documentation of 3-6

months of conservative measures with 3 months being reasonable if treatment has been consecutive. There should be documentation of positive orthopedic signs such as impingement signs and response to a steroid injection. For this individual, while the records indicate the patient has an MRI that is positive for a tear, it is not a full thickness tear as per the MRI. There is documentation of a steroid injection with limited response. However, as stated by the 2 previous reviews, there is a lack of documentation of conservative care as recommended by guidelines in the nature of 3-6 months of conservative treatment. Therefore, it is the opinion of this reviewer that the request for an outpatient right shoulder arthroscopy with SAD, DCR, and RCR with 6 sessions of postoperative physical therapy is not considered 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 and Environmental Medicine um
- ☐ knowledgebase AHCPR-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 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 Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)