

# C-IRO Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Dec/17/2010

**DATE OF AMENDED REVIEW:** Dec/22/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

29822 Left Shoulder Arthroscopy  
23410 Open Left Shoulder Rotator Cuff Repair  
20926 Removal of Tissue For Graft, Left Shoulder

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

M.D., Board Certified Orthopedic Surgeon

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Official Disability Guidelines  
FCE 09/13/10  
09/07/10 to 10/18/10 offices notes of Dr.  
09/30/10 MRI of the left shoulder report  
10/08/10 Office note of Dr.  
Peer reviews 10/19/10 and 11/03/10  
10/27/10 request for surgery

**PATIENT CLINICAL HISTORY SUMMARY**

This is a male injured on xx/xx/xx while pulling a dock plate and his arm was jerked. On 09/07/10, the claimant began treating with Dr. for exercises and work restrictions. The MRI of the left shoulder from 09/30/10 showed a focal 6-7 millimeter diameter full thickness supraspinatus tendon tear anterior laterally at insertion. Associated minimal fluid within the subdeltoid and subacromial bursa was reported. There was abnormal patchy humeral head bone edema anterior medially suggesting impaction from attempted or reduced posterior dislocation. No associated glenoid bony fracture or labral tear was reported. A small acromioclavicular joint effusion of traumatic or inflammatory origin was present.

Dr. evaluated the claimant on 10/08/10 for left shoulder pain and weakness. It was noted that the claimant had treated with physical therapy. Examination revealed pain to the anterior

superior aspect of the left shoulder, pain over the greater tuberosity with palpation and crepitation of the subacromial bursa with gentle motion of the shoulder. Forward flexion was to 100 degrees with pain and abduction of 70 degrees was with pain. External rotation of 25 degrees was performed with pain and internal rotation was to the hip. There was positive forward impingement sign with pain. Positive Hawkins signs were noted. There was weakness against resistance with pain. Diagnosis was left shoulder anterior subacromial decompression with full thickness tear of the supraspinatus tendon. On 10/27/10, Dr. requested arthroscopy left shoulder with possible open repair and 23 hour observation status.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

The reviewer finds that this surgery (29822 Left Shoulder Arthroscopy; 23410 Open Left Shoulder Rotator Cuff Repair; and 20926 Removal of Tissue For Graft, Left Shoulder) is medically necessary. This is based on the patient's failure to respond to conservative care including therapy, activity modification, and exercises. The MRI and examination findings confirm a rotator cuff tear. The ODG Guidelines for this procedure have been satisfied based on a review of the clinical documentation in this case.

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapter shoulder, rotator cuff repair

ODG Indications for Surgery| -- Rotator cuff repair

Criteria for rotator cuff repair with diagnosis of full thickness rotator cuff tear AND Cervical pathology and frozen shoulder syndrome have been ruled out

1. Subjective Clinical Findings: Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. PLUS
2. Objective Clinical Findings: Patient may have weakness with abduction testing. May also demonstrate atrophy of shoulder musculature. Usually has full passive range of motion. PLUS
3. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary views. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.

Milliman Care Guidelines, Outpatient Surgery

**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)